PSYCHD

Exploring enabling environments in approved premises

A Q methodology

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Award date:
2020

Awarding institution:
University of Roehampton

Exploring Enabling Environments in Approved Premises:

A Q Methodology

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A Thesis Submitted in Partial Fulfilment of the Requirements for the degree of

PsychD

Department of Psychology

University of Roehampton

April 2020

Abstract

There is a need to better understand the social and interpersonal processes in environments supporting individuals released into the community from prison. An Enabling Environment forms part of the national Offender Personality Disorder Pathway and are being implemented with all approved premises in the UK. Current research into understanding psychologically informed practice in either approved premises or in Enabling Environments is in its infancy. This research project explores the experiences of staff working in three approved premises over 18-months as they are engaged in implementing an Enabling Environment. Q Methodology was used to; (1) understand how experts define an Enabling Environment; (2) understand how participants experience their environment before any initiative began; and (3) explore how participants experienced their environment with more practical and social-environmental exposure to this therapeutic culture.

The experts define three core components to an Enabling Environment, namely an interpersonal culture based upon social and relational foundations; a systemic framework of how this can be implemented meaningfully; and a practical model to use to actualise these that is consistent with the objectives of the environment and the wider social system. Analysis of the staff participants revealed predominant viewpoints around the need for a predictable and containing environment that offered safety from physical threat. There were also clearer perspectives at the beginning and end of the study associated with acceptance, inclusion, being curious about others, and in meaningfully relating to each other consistent with Enabling Environment principles. Notably, through the research resource limitations and serious incidents detrimentally impacted how the staff related to their environment. This resulted in staff either acquiescing to residents needs or taking a problem-focussed autocratic approach. This was however repaired at the end of the study with an emerging balance of how dilemmas between risk and offering therapeutic relationships are

managed. It is suggested that approved premises achieve an effective service when they can provide residents who have complex needs with a place where they can feel safe, included, where there are boundaries and expectations, and where they are supported in transitioning back into the community after a period in custody.

The findings were discussed in relation to existing literature, salient factors relevant to Enabling Environments in approved premises, and the potential support and supervision that staff may need in delivering and maintaining such environments. Limitations to the study include the fact that Q methodology means there is a more limited ability to generalise the findings beyond the approved premises in the study, the possibility of potential methodological and researcher biases through the development of the Concourse, the small number of participants meaning that the data from the three approved premises was analysed collectively and the fact that research took place at three approved premises that at the time were undergoing structural and organisational change. Recommendations for further research is acknowledged and suggested.

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Ethical Approval

The research for this project was submitted for ethical consideration under the reference PSYC 16/239 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 21.02.17. This project was also submitted for ethical consideration under the reference 17/EM/0034 at the NHS Research Ethics Committee / HRA process (Nottingham 2 Research Ethics Committee) and was approved under these procedures on 14.02.17. Thirdly, this project was submitted for ethical consideration under the reference 2017-007 through the NOMS Ethical Review process and was approved under the procedures of this Ethics Committee on 19.01.17.

Acknowledgements

I would like to thank Dr Charles King for his invaluable supervision and in his capacity for endless reflective thought through this study. I would like to thank Professor Robert Edelman for your vital supervision, guidance and support through this long process. I am very grateful to Professor Steven Brown, Dr Simon Watts and Dr Steven Jeffares for your direction and clarification on aspects relating to Q Methodology.

I could not have completed this journey without my wife Jacinta with her endless resilience, patience and much needed encouragement, or without my children Dylan, Theo and Jacob for being there to ground me so I could keep on writing.

As this was a Thesis integrated into my professional practice, I would also like to extend a big thank you to the Oxford Health NHS Foundation Trust Forensic Services Psychology Department, and especially the Team I work with for their relentless understanding and encouragement.

Finally, I am incredibly grateful for the National Probation Service staff that took part in this study who took time from their busy working lives to offer much of their valuable time.

Chapter One
Overview of the Research

1. Overview of the Research

1.1 Background to the Research

In recent years there has been a drive to better understand the contextual, social, interpersonal and relational processes involved in environments supporting individuals being released into the community from prison. Enabling Environments form part of the Offender Personality Disorder (OPD) Pathway (Joseph & Benefield, 2012). The development of psychologically informed environments, of which an Enabling Environment is one, was a concept propagated in 2010 following many years of clinical and political initiatives in the field of personality disorder (Bolger & Turner, 2013), and is rooted in response to government policies relating to the treatment and management of offenders with complex interpersonal difficulties. A national strategy has begun to be developed to provide both therapeutic environments and to increase access to psychological therapies for people with complex needs (Joseph & Benefield, 2012). The research into both of these areas is developing, however psychologically informed practice is regarded as being in its infancy in the Criminal Justice System (Castledine, 2016). As such there is a paucity of empirical literature relating to understanding such psychologically informed practice in approved premises and to the initiatives and outcomes of the practical and therapeutic work undertaken.

Approved premises provide supported accommodation for individuals who are transitioning out of prison to the community and are a vital component part of supporting and managing high risk individuals with this transition (Cherry & Cheston, 2006). Many of the individuals residing in approved premises have complex needs and are a high-risk group of individuals, regarded as being

amongst the most difficult and hard to reach, often with marked social and psychological difficulties and complex mental health difficulties (Johnson, 2009; MOJ, 2011; Wilkinson, 2005). Approved premises have historically performed a monitoring and surveillance function, however more recently there is a clear movement to effectively and meaningfully engaging and relating to individuals to reduce the risk of further offending (Cherry & Cheston, 2006). The efficacy of this approach has yet to be evaluated.

It is widely recognised that both the external environment and the therapeutic environment or culture is fundamentally important in promoting engagement and participation in such environments (Andrews & Bonta, 2010; Howells & Day, 2007; Ward, et al., 2004). It is thought that this social and interpersonal environment is also salient when trying to support high-risk individuals with their transition into the community from prison. The key principles of therapeutic environments are derived from the acknowledged importance of the quality of meaningful relationships, the availability of an appropriate environment and space, providing a reflective space for residents to develop more understanding and responsibility for their interpersonal behaviours, and providing a supportive, encouraging and curious approach to understanding and engaging with difficult interpersonal behaviours (Joseph & Benefield, 2012; Turley et al., 2013).

The Enabling Environment initiative was developed by the Royal College of Psychiatry (RCP, 2010) and relates to a social and relational therapeutic milieu focused upon good communication, boundaries, belonging, involvement, development, safety, structure, leadership, empowerment and openness (Johnson & Haigh et al., 2012). An Enabling Environment is an empirically derived psychologically informed culture and therapeutic milieu and is regarded as being the platform from which more structured psychologically informed environments are launched (Castledine, 2016). Achieving an Enabling Environment requires submitting a portfolio of evidence of clinical practice for assessment by the Royal College of Psychiatry and requires set criteria to be met and achieved.

An Enabling Environment reflects a good practice environment, where there is a commonality of language about needs, values and approaches, and agendas about the provision of an effective and meaningful environment. It also offers the opportunity to recognise and praise good and effective practice in action. The Enabling Environment process is underpinned by the relationships between people, where responsibility, accountability, involvement in the environment and creativity are promoted and encouraged. Also, decision-making is shared and is transparent, people are valued and supported, and all behaviour, including that which is disruptive is viewed in a meaningful way as a communication to be understood (Haigh & Johnson 2011). These inherent notions reflect the underlying concepts found within therapeutic environments, therapeutic milieu and therapeutic communities (e.g. Morgan et al., 2014; Newberry, 2010; Townsend, 2010; Turley et al., 2013).

Very little research also exists around understanding Enabling Environments, and this is more so in community forensic contexts. Similarly, little is really known about the culture and social-interpersonal environments of approved premises, and research is required to understand the lived experience of working in a more psychologically informed manner (Castledine, 2016). This study aims to explore the subjective experiences of staff working within three separate National Probation Service Approved Premises as they progress through the development and implementation of this psychologically informed environment or milieu, i.e. an Enabling Environment.

1.2 Conceptual Framework

The predominant concept underpinning this research is that when individuals engage in implementing a new social and therapeutic culture they identify with this more implicitly over time. Essentially, how staff perceive their experiences of working within approved premises is largely

unknown, especially one that follows the process longitudinally, and only one study has to date explored the development of an Enabling Environment within an Approved Premise (Davies et al., 2018). Given the changes being implemented, an evaluation of this process of is crucial to enable ongoing reflective learning within the organisation and to allow feedback to staff, residents and stakeholders in order to improve the service and care delivery (e.g. Bowers et al., 2006). Similarly, it is important to understand the nature of these environments and what aspects contribute to positive therapeutic spaces, especially given that staff are persistently dealing with individuals with complex needs, challenging behaviour, and interpersonal and mental health difficulties. For example, Shaw et al. (2012) investigated the impacts of a psychologically informed model for Probation Officers working with challenging individuals, including those with personality disorder. They found that the process of developing and implementing the model resulted in an increased awareness of how staff view of their competencies and capabilities, their knowledge increased in identifying risks and needs, planning for treatment for complex individuals and their ability to know how to seek out specialist support. Staff however described that they felt less resilient and perceived fewer benefits to the wider team climate.

Furthermore, having a framework that can be used to repeat comparisons of the social and therapeutic culture between the different approved premises would be useful for the future monitoring and management of these environments, and in the provision of support for the staff. This research will explore the experience of staff working in approved premises as they are engaged in the development of an Enabling Environment initiative which is an empirically derived psychologically informed culture and therapeutic milieu.

1.3 Overview of the Research Method

This project will use a Q Methodological design which is regarded as a Qualiquantilogical methodology (Stenner & Stainton-Rogers, 2004), i.e. a mixed method research design as it integrates aspects within qualitative research with the ability to apply statistical analyses found within quantitative methods (Newman & Ramlo, 2010). This statistical thoroughness is rooted in the psychometric and operational principles in the methodology and within the correlational and factor analyses that are applied to the data analysis to make it a systematic and rigorous quantitative method for exploring human subjectivity (McKeown & Thomas, 2013). Q Methodology is a method designed to explore the individual viewpoints of participants, or the notion of subjectivity around a given theme or topic. In Q Methodology, what is being explored is the concept of 'psychological significance', or operant subjectivity through how participants conceive and communicate their thoughts, beliefs, attitudes and values about a given subject topic (McKeown & Thomas, 2013; Paige & Morin, 2016).

Q Methodology is underpinned by a social constructionist empiricism, which like the notion of constructivism is concerned with the individual meaning and significance of how people make sense of their social and physical world (Watts & Stenner, 2012). Social constructionism is focused upon social and sociological meaning, i.e. the interpretation and meaning attributed to collections of subjective viewpoints or the shared social significance. Given this empirical foundation, Q Methodology is well suited to understanding the collective perspectives of individuals that are thought to be representative of the environment or context being studied (Patton, 2002; Watts & Stenner, 2012). Furthermore, Q Methodology is not a hypothesis testing process and results are not meant to be generalised to wider populations as in more conventional quantitative research methods. The benefit of Q Methodology is the ability to bring a sense of coherence to

understanding what specific research participants subjectively understand about a topic, and therefore what is significant from their perspective about this given topic (Watts & Stenner, 2005).

Q Methodology remains essentially a phenomenological approach, in that it is concerned with how people make sense of their experience of the world around them (Bryman, 2001; Langridge, 2007). It however does so by permitting more specificity in how these viewpoints make sense, both individually and collectively by integrating these perspectives within the wider social meaning being investigated. Q Methodology was chosen for this study because it will allow for a more implicit exploration of the meaning given to engaging in a therapeutic culture by the staff within the approved premises. This is because individuals rank statements in relation to each other in the sorting process as opposed to rating statements individually within a questionnaire or survey design study (i.e. explicit interpretation). Similarly, by ranking and sorting as a holistic process, meaning is applied to the statements as a representation of their collective viewpoint on a subject rather than viewpoints on the component parts. Likewise, unlike conventional qualitative methodologies which do not allow for a robust and statistically rigorous way to evaluate change over time, Q Methodology allows for qualitative subjective experiences to be quantitatively analyzed across several timepoints. Here, although it is not conventionally a test of difference, the perspectives of two different groups can be meaningfully statistically compared after the initial analyses of each group has been completed using theoretical and statistical comparisons of each group and individual members between timepoints (Watts & Stenner, 2012). The use of repeated measures design and analyses using Q Methodology is well established (e.g. Ablon & Jones, 1998; Bambery et al., 2007; Block, 2008; Freie, 1997; Gaebler-Uhring, 2003; Popovich et al., 2003).

1.4 Purpose of the Study

The purpose of this study is to explore the collective meaning to and experience of the developing therapeutic milieu and social culture (i.e. the Enabling Environment) experienced within three approved premises by the staff across time. The research therefore asks the participants what they feel is important within their own environment to understand their individual subjective experiences of what they feel forms the culture and therapeutic environment of that space. The study explores whether the participant's perspectives towards this space changes over time with more practical and social-environmental exposure to this therapeutic culture. This study also aims to define the nature of an Enabling Environment as it exists within approved premises and to understand the developing organisational culture that exists within these approved premises.

The aims of the research are as follows;

i. Study One aims to develop an understanding of what represents an ideal Enabling Environment using participants considered experts in Enabling Environments and therapeutic settings. This Study will be used to develop a gold standard or 'prototype' to compare to each timepoint.

ii. Study Two (Part A) has two objectives. The first objective is to explore the meaning and significance of how the participants make sense of the approved premise environment before the Enabling Environment initiative commences. The second objective will explore the experience of staff working in the approved premises as they are engaged in the process of becoming an Enabling Environment over an 18-month period. The aim is to explore what the participants understand to be important within their own environment and to understand the collective subjective experiences of what forms the culture and therapeutic milieu of that environment across time.

iii. Study Two (Part B) will explore whether the participant's perspectives of this therapeutic environment and culture change over time with more actual, practical and social-environmental exposure to the Enabling Environment culture. The objective is to explore whether staff shift in their views (moving from explicit awareness to implicit understanding) of the Enabling Environment as they progress through the process. This is achieved by both a qualitative comparisons across time and the use of the prototype developed from the experts to compare to collective viewpoints at each approved premise as they progress through the Enabling Environment initiative. In this there is a logical supposition that staff view of the Enabling Environment culture will more aligned with the expert views of the Enabling Environment culture the closer the environment is to being awarded the Enabling Environment status.

Chapter Two:
Review of the Relevant Literature

2. Review of the Relevant Literature

2.1 The Personality Disorder Framework

Since the Department of Health seminal paper about working with people with personality difficulties i.e. "*Personality Disorder- no longer a diagnosis of exclusion*" (NIHME, 2003) there has been an escalating awareness and recognition that there is a large body of people with complex mental health difficulties who either do not engage with mental health services or who are often misdiagnosed, inadequately treated, and often dismissed as untreatable (Johnson, 2013). Individuals with forensic histories and personality difficulties pose a significant number of challenges for professionals working with this client group (Shaw et al., 2012). There is also the increasing necessity to recognise and address the high levels of personality and mental health needs in prisoners (Joseph & Benefield, 2012; Singleton et al., 1997) as it is known that working with challenging patients can be difficult and often creates a highly charged environment (e.g. Singleton et al., 1997).

Of note, NICE (2014) estimated that around 90% of prisoners and 39% of adults serving community sentences have marked psychological difficulties that would result in a clinical diagnosis. Similarly, it is identified that over 25% of individuals residing in approved premises would also receive a psychiatric diagnosis. Furthermore, with regard to personality disorder diagnoses, it is estimated that 60-70% of the prison population meets the criteria for at least one form of personality disorder (Singleton et al., 1997), and that this is as much as between 50 and 66 % of the National Probation Service caseload (Blumenthal et al., 2009; Brooker et al., 2012; Stewart, 2008).

The Bradley Report (Bradley, 2009) provided clear guidelines that multiple agencies should be developed for individuals with these complex needs in custody and into the community because of the increased support required. Given this, new pathways of care and support were developed to help individuals transitioning into the community from secure settings (Bolger & Turner, 2013). Over the past seven years there has been significant reorganisation of the National Probation Service, particularly with the Transforming Rehabilitation agenda by the U.K. Government (Davies et al., 2018). Within this wide Transforming Rehabilitation agenda, alongside large-scale organisational restructuring in 2014, a national Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide therapeutic environments and access to psychological therapies for people with complex needs. This has been suggested to be especially relevant in working with individuals with personality difficulties (Shaw et al., 2012) because the culture and environment of services working with such individuals is directly linked to their engagement and adherence to these services (Andrews & Bonta, 2010; Howells & Day, 2007; Ward et al., 2003).

As such, in the last few years psychologically informed strategies have been developed as part of the national Personality Disorder Strategy within both custodial and community services (Joseph & Benefield, 2012) because of the requirement of responsive environments to address these difficulties, especially in the transition into the community. A number of therapeutic environments have since been developed to address the needs of staff and individuals living within settings supporting individuals with complex needs, including Psychologically Informed Planned Environments (PIPE's), Psychologically Informed Environments (PIE's) and Enabling Environments that represent a psychosocial initiative (Castledine, 2015; Haigh et al., 2012). Importantly, all residential services (i.e. prisons and approved premises) within the national Offender Personality Disorder Pathway are expected to achieve Enabling Environment status (Benefield et al., 2015).

2.2 Approved premises

An approved premise is a 24-hour staffed supportive residential environment designed to support high-risk individuals and people with more complex needs as they are released from prison into the community. They are suggested to have two primary roles; “to help rehabilitate and resettle some of our most serious offenders, and to make sure that the public are protected in the offenders’ early months in the community” (HMIP, 2017, p. 4). The National Probation Service is responsible for the management of 89 approved premises, with a total of almost 2,000 bed spaces. In 2014-15 these approved premises employed just over 800 staff and provided places over the course of a year for more than 11,000 residents (NPS, 2016).

As such, approved premises are regarded as being a vital component part of supporting and managing high risk individuals with their transition from prison into the community (Cherry & Cheston, 2006). However, there is a relative paucity of literature relating to the initiatives and outcomes of the practical and psychologically informed work undertaken in approved premises here in the UK, and psychologically informed practice is regarded as being in its infancy in the Criminal Justice System (Castledine, 2016). This is however beginning to change with the recognition of the need for increased support and the development of new initiatives designed to provide support to staff working in these settings, of which psychologically informed practice and Enabling Environments are examples. An early review of approved premises in 2005 (HMIP, 2005) suggested that “the use of structured and supported accommodation, which is matched to the needs of offenders can assist with maintaining an offence free lifestyle” (p. 35). This is in the context of the finding that over 60% of residents at approved premises are regarded as being high risk of harm (Foster, 2004).

Approved premises work with offenders who are transitioning out of prison to the community, and therefore have complex needs and are a high risk group of individuals. They are amongst the individuals with the most difficult and hard to reach social and psychological difficulties and complex mental health difficulties, alongside those in homelessness hostels (Johnson, 2009), the prison service (MOJ, 2011), and those that present at Accident and Emergency services (Wilkinson, 2005). Ryan et al. (2005) explored the input from a specialist mental health service into seven approved premises in the UK. They found that the service which was designed to assess individuals and provide brief interventions, as well as promoting professional links with mainstream mental health services had a positive impact on care and treatment of individuals with complex mental health difficulties. Bruce et al. (2017) explored a number of interventions that underpin psychologically informed practice at an approved premise in North London. They found that the implementation of staff training in therapeutic alliance and understanding personality difficulties, offering consultation and case formulation to staff, and helping staff to understand stress and burnout led to a reduction in the number of warnings given to residents of the approved premises. These interventions also reduced the number of resident's recalled back to custody due to breaches of their probation license. Similarly, Ramsden et al. (2014) who also offered case consultations and developed psychologically informed formulations with team members within an approved premise in the North East of the UK found that engagement with staff and developing a psychologically led formulation-driven approach resulted in improved outcomes for staff in being able to support the residents within the approved premises.

Clark and Chuan (2016) found that offering similar psychologically informed support to Probation Officers at the same time as to approved premise staff resulted in a significant decrease in the rate of individuals recalled back to prison in the first three years of the study; rates of non-compliance with supervision were reduced by 60%; challenging behaviour in the approved premises reduced; and there was no evidence of any significant increase in serious further offending across the three

years. Similar outcomes have been suggested by joint working initiatives between Probation Service staff and mental health services within approved premises (Bourne, Rajput & Field, 2015; Stevens et al., 2011).

A number of important factors have been identified as being necessary for environments such as approved premises to be effective and responsive, including having a well-led staff team who understand the key principles of the regime and how the teams need to be responsive to the risk and needs of the residents (Latessa & Lowencamp, 2002). Cherry and Cheston (2006) also identify core elements to an effective structure within an approved premise, including resident's stay being planned, active encouragement to engage in pro-social activities and interventions to increase life skills, promoting access to vocational, employment and educational services, and access to physical and mental health services.

In contrast, difficulties have been found in how services within approved premises meet the social and psychological needs of high risk and complex patient groups, including for example with sexual offenders (Reeves, 2013) and elderly individuals (Forsyth et al., 2013). It is suggested that face to face work with residents of approved premises is imperative (Cherry & Cheston, 2006), however if there is an increase in psychological working without positive support and leadership, studies have found that staff can experience alienation, feelings of wishing to disengage and feeling stuck in their practice which can result in increased vulnerability to stress and burnout (Scanlon & Adlam, 2012). Furthermore, Nathan et al. (2007) suggest that frequent emotionally charged interactions between staff and patients increased the risk of stress and staff burnout. As such, the notion of a critical occupation (Paton & Violanti, 1996) is suggested to be relevant to this context, i.e. individuals who are likely to encounter a greater risk of exposure to potentially traumatic events that may cause a critical impact on psychological well-being under certain circumstances (Clarke, 2007). This is suggested to be the case for individuals working in approved premises given the nature of the role

working with high risk individuals with complex needs, often with personality difficulties and mental and physical health needs.

Castledine (2016) investigated staff experiences of developing and implementing a psychologically informed and planned environment (PIPE) within an approved premise using a thematic analysis methodology. The study investigated the predominant experiences that arose from in-depth interviews with six staff members, which although is a comparatively small sample size and the study was restricted to one approved premise where the author also led the service clinically, the findings are very useful. The findings were grouped into three main themes, *the benefits*, *the challenges* and *staff perceptions of their roles*. In regard to the overarching theme of *the benefits*, four component sub themes were identified; increased psychological knowledge and understanding, the experience of it being a learning journey, increased communication and engagement and an increased thinking and reflection in therapeutic relationships with the residents. Particularly, it is purported that the increased understanding of psychologically informed practice was experienced as being coaligned with the day to day work of the Probation Service approved premises, as opposed to being seen as additional tasks or as separate to day to day practice.

The theme of relating to *the challenges* refers to the difficulties staff experienced on a day to day basis. This overarching theme was identified to have three component subthemes, including; the negative psychological impact of the work (i.e. at work and in personal lives), the experienced lack of time to undertake therapeutic tasks as effectively as is desired and a conflict between their roles, i.e. between the therapeutic processes and the notion of risk management. In support of this, Hurst et al. (2015) suggested that staff working within approved premises that functioned as PIPE's found the role challenging, but also valuable, particularly that they valued the support and supervision they were offered.

In relation to the theme of *staff perceptions of their roles*, three component sub themes were also identified, including; the staff perception of their relationships with the residents, 'wearing two hats' in their role and the therapeutic process being seen as a different approach compared to conventional support and supervision of residents. It was identified that supportive relationships with residents were found to be constructive and meaningful, but that balancing the therapeutic relationship with the notion of risk management was found to be a dilemma often faced by the staff. This was however moderated by training, support and leadership.

These concepts defined through this study help us to understand that developing and implementing a new way of working within an already established culture has rewards and limitations. Particularly, although it was found that the staff embraced the new learning and there were positive experiences on engagement and reflective ability with the residents; the staff found relating to the residents an emotionally challenging process, there were complexities in adapting to the new way of working on top of their core function as an approved premise, and that this created conflicts in how they balanced their roles between being therapeutic and managing public protection. This is consistent with other previous findings in the difficulties in individuals managing these dual roles (Marshall & Adams, 2018).

More recently a multisite longitudinal study examining the impact of Enabling Environments in approved premises has been undertaken (Davies & O'Meara, 2018) as well as in both approved premises and prisons (Davies et al., 2019). Importantly, Davies and O'Meara (2018) conceptualised their study because of the necessity to establish a baseline understanding of the lived experiences, attitudes and well-being of those living and working in these approved premises prior to a major organisational change in the Probation Service, including within approved premises, namely the E3 initiative. Under the umbrella of the Transforming Rehabilitation agenda in the Probation Service, all approved premises in the UK have been expected to shift from independent operating

procedures and to restructure logistical and operational policies and staffing structures to standardise the way that these environments operate (NOMS, 2015). This new model of working termed E3, or 'Effectiveness, Efficiency, and Excellence' (NOMS, 2015) was identified in 2015 and put into operational practice across 2016 and 2017.

In their paper benchmarking the first 12 months of this longitudinal study, Davies and O'Meara (2018) investigated four approved premises over a 12-month period prior to E3. They investigated well-being, life satisfaction, attitudes towards violence and problem-solving abilities with the residents; and attitudes to personality disorder, well-being and stress / burnout with the staff group. The purpose of this initial study was to achieve a baseline understanding of these aspects within the approved premises prior to the organisational change using a mixed-methods design that included psychometric questionnaires and narrative-style interviews with 114 residents and 30 staff members. They found that overall there were comparable perspectives between the staff and the residents towards all of the factors measured using the questionnaires, but that the residents expressed significantly less well-being, life satisfaction and general happiness but that they reported a greater sense of safety in the approved premise. When the data was compared to normative data from previous studies, they identified that the resident group rated the atmosphere of the approved premises as being more positive than prison samples and with less experienced anger. Similarly, the staff group reported lower experiences of it being a supportive climate yet reported a greater sense of safety and of mutual support than comparative prison populations.

Furthermore, the staff reported a more favourable attitude to working with individuals with personality disorder than was found in a comparative sample from a high secure psychiatric setting. Although the study did not include all staff and residents in the sample and participant numbers for some analyses were too small to confidently identify difference, these findings are important given that how staff experience their environment, relate to and engage with the residents are important

components to foster a meaningful supportive environment. Similarly, it is important that residents are able to feel safe and not treated with negative or pejorative attitudes by staff because of their forensic history or their interpersonal difficulties.

Using the sample from the above study (Davies & O'Meara, 2018), Davies et al. (2019) followed up these four approved premises alongside three prison sites over a subsequent 24-month period. This study had particular focus on the process of engaging in the Enabling Environment initiative and explored the progress of these seven sites in achieving this. The authors used a thematic analysis methodology exploring the perspectives of staff, the residents / prisoners and commissioners. They found that the progress at achieving the Enabling Environment process across all sites was fraught with difficulties and delays. They identified that engaging in the Enabling Environment process is complex and multifaceted with little clear guidance on how it should be implemented. Core elements that interfered with the capability for the approved premises to engage in the Enabling Environment process included a lack of ability to build trust between staff and residents underpinned by staff changes and high turnover of staff.

The authors also identify four key learning points from this study that included the need to recognise the Enabling Environment process as an organisational change and treat it as such given the demands required and its transformational nature. Secondly, that leadership should be engaged in a democratic manner with staff to help them understand the nature and purpose of the process to minimise resistance and feelings of being 'done to'. Thirdly, that those directive in applying the Enabling Environment principles and engaging the residents in the process need to 'buy in' to the principles and need to have sufficient knowledge and ability to make theory-practice links in their activities. Finally, it is suggested that leadership through the Enabling Environment process is an essential scaffold to underpin the other principles, especially in the value of guidance and support, and in setting and maintaining goals.

2.3 The Relevance of Organisational Change

Importantly, Davies and O'Meara (2018) suggested that implementing the Enabling Environment standards within approved premises should be regarded as an organisational change process parallel to that already being undertaken, i.e. E3. The presence of this and E3 as an organisational change is important to identify given its relevance to this current study as data was collected longitudinally across the time when the E3 was also being implemented within the sites providing the participant samples.

Organisational change can be defined as a shift from a current unwanted position to a desired future state within a particular setting (Nelson & Kletke, 1990). Change can be cultural, structural, operational or logistical and therefore often requires employees to function in a different way (Mack et al., 1998). Responding to changing organisational and clinical needs in healthcare settings is a dynamic and adaptive process, and although modern forensic healthcare requires staff to work in a climate of rapid change (Stanley & Swan, 2005), by its very nature change can be destabilising and it is regarded as one of the most significant causes of stress (Ashford et al., 1989; Leigh et al., 1988; Upton & Brooks, 1995) and uncertainty (Coulson-Thomas, 2009; Shaw, 2002). For example, with regard to the E3 organisational change, Castledine (2016) in the qualitative exploration of a PIPE approved premise identified that the new national changes to the staffing structures presented as a mitigating factor in how the staff internalised and actioned the psychologically informed way of working. It was identified that anxieties about job roles, job security and anxiety about the organisational change were impacting on how meaningful the therapeutic environment was seen to be.

Within the literature, there have been a number of studies investigating the effects of stress within health care settings, including with social workers (Evans et al., 2006), health teams (Nathan et al.,

2007; Fichtner et al., 2001), specialist forensic settings such as professionals working with sexual offenders (Clark & Roger, 2007) and with Probation Officers (Robinson & Burnett, 2007). Similarly, there are a number of authors who have investigated the relationship between stress and organisational change in secure services (Long et al., 2008) and acute admission services (Bowers et al., 2006). It has been argued that current problems in managing change are due to employee openness towards change, perceptions of the change and coping strategies people use through change (Devos & Buelens, 2003; Mack et al., 1998; Marshall & Olphert, 2009). It could therefore be argued that organisational change is mediated through an individual's ability to change, and therefore, a fundamental reason why organisational change is difficult to achieve is the complex psychological nature of individuals (Devos et al., 2002).

Clinical and organisational change needs to be responsive, needs led and evidence-based, and understanding this complexity is especially significant when implementing an organisational change in specialised and forensic services because the working environment intrinsically involves a high risk of stress (Paton & Violanti, 1996; Clarke, 2008). Furthermore, research relates stress to a reduced capacity to use skills (Van Yperen et al., 1992), exhaustion (Maslach et al., 1996) and an inability to cope with the demands and pressures of a job (Cherniss, 1993; Pick & Leiter, 1991), the erosion of autonomy, a decreasing sense of control over work and isolation from other team members (NHS, 2007). The saliency of each of these factors is highly relevant when implementing such an organisational change within a setting where there is a core reliance on healthy relating between staff and service users, and where the staff are responsible for creating a safe and meaningful environment or culture. Ward atmosphere as one example of this is defined as the complex social and therapeutic features of a healthcare or treatment environment (Schalast et al., 2008) and is suggested to be integral to the development and maintenance of an effective therapeutic environment (Bowers et al., 2006; Doyle et al., 2017; Livesley, 2007). There has

however been little published literature regarding organisational change and ward atmosphere in specialist forensic services.

Research available in evaluating the treatment climate in general psychiatric settings suggests that ward atmosphere is related to job satisfaction (Dorr et al., 1980), staff performance and morale (Moos & Schafer, 1987), treatment outcomes (Beech & Hamilton-Giachritsis, 2005), attitudes towards treatment (Squier, 1994) and stress (Kirby & Pollock, 1995). Additionally, the role of stress is found to be an integral part in mediating staff attitudes and beliefs about the value of the treatment climate within services (Carr-Walker et al., 2004; Howells, Krishnan & Daffern, 2007). It can therefore be argued that perceptions of ward atmosphere are affected by stress (Car-Walker et al., 2004; Kirby & Pollock, 1995; Howells et al., 2007) and that stress due to organisational change is likely to affect ward atmosphere (e.g. Nathan et al., 2007; Rigby et al., 2001). This is in addition to the suggestion that developing and maintaining a therapeutic environment is a difficult task (Howells et al., 2007), especially when working with individuals with interpersonal dysfunction (Nathan et al., 2007) such as within approved premises.

2.4 The Principles of a Therapeutic Environment

Moos (1973) conceptualised a therapeutic environment as being an interrelated and overlapping relationship between organisational structure and climate, the social climate and milieu, the characteristics of individuals residing in such environments and the means that change is reinforced or supported within such environments. Similarly, Davenport (2009) advocates that for a therapeutic environment to be meaningful, it needs to be highly supportive, focussed on interpersonal relationships and individual needs, as well as where individual patient views are

considered, and there is empowerment for individuals to make personal choices about their treatment.

Building upon these early foundations, Grencavage and Norcross (1990) through systematic reflections on the literature pertaining to therapeutic processes identified five core elements that pervade across meaningful therapeutic environments. These include; (1) client characteristics (e.g. readiness, treatment seeking / refusing), (2) therapist qualities (e.g. person centered, warmth and openness), (3) the change processes (e.g. a structure and understanding of treatment), (4) treatment structures (e.g. the use of therapeutic processes techniques), and (5) relationship elements (e.g. the therapeutic relationship, culture or milieu and engagement with individuals). Similarly, Nelson (2017) proposes that there are three core components to implementing a positive therapeutic environment within any setting. These are (1) an evidence-based implementation, i.e. that the culture is grounded in literature and research; (2) there is supportive organisational development, i.e. that the system supports and promotes this therapeutic structure and resources are offered accordingly; and (3) that open collaboration is encouraged between providers and recipients of the therapeutic environment.

Haigh (1999; 2013) has written extensively on the nature, structure and function of social and therapeutic environments, therapeutic culture, climate and the therapeutic milieu within a variety of psychologically informed environments. In a more recent paper (Haigh, 2013) five core principles are defined that are suggested to be the quintessence of a therapeutic environment. These are (1) attachment, (2) containment, (3) communication, (4) involvement and inclusion and (5) agency. These will be explored individually. The principle of *attachment* is underpinned by psychological theoretical models of attachment (e.g. Bowlby, 1969), and is reflected in a therapeutic culture as the social concept of needing to experience of a sense of belonging and relatedness to the environment and the community therein. It derives from the principle that individuals need to feel

safe in their relationships to each other and to the meaning and purpose of the therapeutic culture as a process within itself.

The principle of *containment* is underpinned by the theoretical models put forward by Winnicott, (1960), in that individuals within a therapeutic culture need to be able to experience boundaries to what they can expect and hope to experience, and that these are set through the rules, structure and objectives of the particular environment. These boundaries, and the predictability of the relationships and social expectations therin, as well as feeling safe with these relationships underpin the important sense of dependability and reliance on the group culture. The *communication* principle relates to the need for a 'buy in' to a sense of openness and transparency in how individuals communicate with each other within the therapeutic culture. It is suggested openness promotes a greater understanding to how the environment and others within it can support an individual, but also how the individual themselves can rely upon the social system to address their individual needs and difficulties. The notions of sharing, offering feedback and being open to challenge, as well as acceptance and being non-judgemental in the way that people interact are core elements.

The principle of *involvement and inclusion* is related to the living-learning principle underpinning therapeutic communities (Jones, 1968), and is characterised by the shared experience of the community within the therapeutic culture, being experienced as having others in mind and feeling held in mind by others in the social environment. It is important that individuals experience themselves as being part of the social environment and that they feel a contributory membership to that culture. This is suggested to foster interdependence, trust, autonomy and a sense of agency through the meaning experienced in the relationships with each other. Finally, the principle of *agency* reflects an ethos of empowerment of the individual to develop social and interpersonal accountability and responsibility for both their thoughts and emotions, but also their social

interactions and behaviour. This position has to be supported by the experience of safe, trusting and reliable social relationships, as well as by the micro and macro contributions within the therapeutic environment (Moore & Dietze, 2005).

It is widely understood that the effective care and treatment of individuals with complex psychological needs relies upon individual factors as well as those inherent in the treating team, the environment and the organisation as a whole (Markham & Trower, 2003). Shine (2010) identified the need for a holistic approach to treatment, but that the most salient aspects fall within the in vivo social interactions between individuals and the day-to-day interactions and relationships within the social context of the environment. In that context, therapeutic alliance and an experienced sense of safety are regarded as being important (Bos et al., 2012), as are positive and genuine communication and interactions (Van Kessel & Van der Linden, 1991). For example, Marshall et al. (2013) identified that the key features of the therapeutic process when engaging and working with individuals with complex difficulties included the therapeutic style or interpersonal characteristics of the therapist, the therapeutic alliance experienced between the therapist and client and the therapeutic climate of the group. Importantly, the therapists' interpersonal and therapeutic style and the way the clients perceive the therapists' style appear to be major determinants of both the therapeutic relationship and the treatment climate within the environment.

Bloor et al. (1988) suggest that there are many different kinds of therapeutic environments which differ in their social organisation and their approaches to the treatment environment. Given that the Enabling Environment initiative was conceptualised and developed based upon the set of standards by which formal therapeutic communities operate (Johnson & Haigh, 2011), it is important to briefly define these.

Therapeutic communities were pioneered by Maxwell Jones (Jones, 1952; 1968) within psychiatric hospitals in the United Kingdom in the early 1950's. The core element is that individuals within such environments are influential as participants and recipients of therapeutic processes with one another (Gill, 1967). They experience a living-learning situation underpinned by a culture of enquiry (Kennard, 2004; Main, 1989). Furthermore, the process of those engaged in the treatment in identifying with positive role models has been found to be core to this process (Gill, 1967), that the essential treatment goal is that individuals shift their social value systems to be more akin to those providing the care or treatment (Rosenthal, 1955). Van Ginken and Stevens (2013) suggest the benefits of therapeutic communities can largely be derived from the quality of relationships, the democratic therapeutic culture and the increased sense of responsibility that is offered to residents. Similarly, Pearce and Pickard (2013) hypothesise that two specific but interrelated factors contribute to the effectiveness of therapeutic communities which are central to establishing and maintaining behavioural change. These are the promotion of a sense of belongingness which is correlated with improved self-esteem, psychological well-being and the capacity for responsible agency. Similarly, Debaere et al. (2016) qualitatively explored the experience of residents engaged within a non-residential therapeutic community in Belgium and found four key concepts that were experienced as being fundamental to the therapeutic experience. These were feeling safe to challenge and care for others, developing a sense of identity in how one relates to each other, identifying patterns of one's own thinking and feeling and working towards a new way of understanding themselves and making new decisions.

The objectives of a therapeutic community have been found to help individuals to improve their self-confidence and sense of self-worth, develop positive relationships with the aim of developing greater consideration for the feelings and behaviours of others, and in forensic settings to reduce the risk of reoffending (Newberry, 2016). It is the 'living-learning' experience that is suggested to

be salient within a therapeutic community in being effective in treating men with complex emotional and interpersonal needs (Akerman & Mandikate, 2018).

The therapeutic community model is suggested to be the forerunner of the biopsychosocial model and the recovery paradigm (Adshead et al., 2011), and applications of this approach have been implemented in a variety of forensic settings (Shuker, 2018). As an example, Greenall (2004) undertook a rather unique qualitative investigation involving only one prisoner within a prison-based therapeutic community and found eight core themes were important to that individual in that environment. These included that therapeutic communities are a better environment with better interpersonal relationships, there is more help available, they are safer, they are more structured and hierarchical, have groups and group work, are more challenging, provide confrontational assistance and have incentive schemes. Although the findings are unilateral and lack robustness to be generalised to wider forensic settings, it is a helpful understanding of the lived subjective experience of an individual within such a therapeutic community.

2.5 Defining a Therapeutic Culture

The therapeutic culture or climate of a setting is often used interchangeably with the term therapeutic milieu and is considered be a treatment modality (Solomon-Mazzanti, 2000; Thomas et al., 2002), where those involved in working within such environments have a role in the creation and maintenance of this (Peplau, 1989). Within any environment considered to be therapeutic, the climate is the therapeutic interrelationship between staff and service users working towards a common collaborative treatment aim or objective defined by the beliefs, values, and norms that comprise the function of those relationships (Deninson, 1996). Bender (2005) suggests that the application of any model of care in a psychiatric environment requires a therapeutic milieu, and

that this interpersonal environment is both the stage for problematic interpersonal relationships to occur and a meaningful agent of change of these dysfunctional relationships.

Importantly, positive therapeutic climates are likely to promote the psychological well-being in patients, reduce environmental stress and increase the effectiveness of therapeutic interventions (Howells et al., 2009). The clinical value of the therapeutic climate as a modality for change was first articulated by Bion (1961) in his involvement in post-war therapeutic communities. This was followed by Moos (1973) and by Main (1989), and the importance of institutional climate itself as a construct has been recognized for over 40 years. Following these early footholds, a therapeutic culture is regarded as being important for meaningful and effective psychological and psychosocial engagement and change (Lipsey & Cullen, 2007).

Peplau (1989), defined a therapeutic milieu as having both structured and unstructured components, with structured elements being aspects such as community meetings, more formal interactions and therapy groups; and unstructured aspects being the diverse and often informal interactions between patients, staff, and visitors that take place throughout the environment. These were the elements of treatment that were of most interest to Peplau and are those that are suggested to constitute the key ingredients to psychologically informed environments such as an Enabling Environment.

Townsend (2010) suggests that the basic functions of any effective therapeutic culture is a sense of containment, an experience of support, a positive structure, an experience of involvement in the environment and the presence of validation of residents as individuals and their psychological difficulties. These are paralleled by Bennett and Shuker (2010) who suggest five core principles of a therapeutic culture within forensic settings, namely respect, openness, the ability to challenge, developing trust and encouraging responsibility. Each of these concepts are suggested to be

anchored around a management or supervision approach and is dependent upon the nature of the environment and the types of social and therapeutic activities that are available (Tew, 2017).

The perceived climate or milieu of a therapeutic environment can be one of the most important factors of the experience of those receiving it. For example, it has been found to positively impact treatment outcomes (Beech & Hamilton-Giachritis, 2005; Rossberg et al., 2008), treatment responsivity (Casey et al., 2007; Howells & day, 2003), satisfaction of service users and staff (Middelboe et al., 2001; Morgan et al., 2014; Rossberg & Friis, 2004b) and impact external treatment variables such as staff performance and morale (Moos & Schaefer, 1987). The therapeutic climate has also been suggested to be highly important within a number of treatment settings, including within substance misuse services (Kelly & Welsh, 2016), inpatient forensic settings (Miller, 2011) and the treatment of sexual offenders (Marshall & Burton, 2010). Bowers et al. (2006) noted that positive climates promote psychological well-being in patients, a reduction in environmental stress experienced by staff and patients, and an increase in the effectiveness of therapeutic interventions. However, in their investigation of therapeutic and social climate in high secure psychiatric settings they found that staff and patients differed in their perceptions of the social climate of the ward environments, where patients reported more negative perceptions of therapeutic support, satisfaction with the general milieu and perceptions of general ward atmosphere when compared to staff. As such it has been suggested that in some settings, the attitudes and approaches of staff towards the care of patients has been perceived as the primary contributors to affecting the therapeutic atmosphere (Stickley & Hui, 2012). To exemplify this further, Collins and Nee (2010) in their exploration of the experience of therapists delivering sexual offending treatment suggested a fundamental conflict exists that affects the ability for patients to make meaningful change, namely the contradicting aims between the therapeutic process and the custodial environment in which the treatment takes place.

Given that therapeutic culture is underpinned by the complex relationships between staff and service users and is fostered and maintained by those delivering the environment, understanding how staff navigate these relationships is important to understand how recovery-oriented practices can be supported and improved (Marshall & Adams, 2018). Frank & Frank (1991) identified that an effective therapeutic approach needs to involve a meaningful relationship with those providing therapy, that the person believes that the therapy can help them and that there is a framework and structure to understanding and addressing their difficulties. As such, research suggests that therapeutic relationships have been found to be more meaningful and effective when those delivering care and support are engaged in a mutually collaborative, respectful, open and trusting relationship with those in receipt of it (Foreman & Marmar, 1985).

From a staff perspective, Totman et al. (2011) suggest that positive morale amongst staff on inpatient psychiatric wards is an important requirement for developing and maintaining therapeutic alliances and is necessary for the successful implementation of therapeutic processes. Likewise, within forensic settings, staff developing supportive relationships with patients can provide them with positive models of relating to others to serve as a framework to rely upon for meaningful interpersonal relationships (Nijdam-Jones et al., 2015). However, for this type of modelling to be effective, there needs to be consistent communication about expectations, clear boundaries, and a shared understanding by the treating team about the attitudes and behaviours being modelled (Cherry & Cheston, 2006). Similarly, Cherry and Cheston (2006) suggested that in forensic settings this way of relating socially and therapeutically is enhanced by staff having clearly defined roles, the presence of supportive leadership and well-designed organisational procedures; but inhibited by a lack of recognition of the therapeutic culture by the wider organisation, low staffing levels and the high risk of interpersonal violence.

Within the conceptual and research literature relating to therapeutic culture and milieu, the concept of the social climate within these environments has had much exposure, and its value has been recognized for many years (e.g. Moos, 1997). Social climate can be defined as the social perceptions and social experiences of an environment that are shared by the group (Bennett, 2010). This is qualitatively different to the notion of a more formalised therapeutic structure which links more closely to the structured elements of a therapeutic milieu defined by Peplau (1989).

Middelboe et al. (2001) suggest that the social climate of a treatment setting is a significant influencing factor in the psychological well-being of the recipients of that environment and in their adherence to treatment. Schalast (2000) has also found that the social climate in treatment environments is essential for motivation for treatment and that social support is a key to motivation to change. This has also been found to be indispensable in psychosocial interventions (Beutler et al., 2000) of which an Enabling Environment is one.

There are a number of assessment measures developed to assess the social climate of therapeutic settings, and these have a number of factors in common with the concepts inherent within an Enabling Environment. The most widely used assessment measures has been the Ward Atmosphere Scale (WAS; Moos & Houts, 1968). This is a 100-item questionnaire validated to explore the presence of ten core concepts relevant to an effective and meaningful social climate. However, this scale although qualitatively helpful, lacks internal consistency and validity and does not stand up to factor analysis to support the item constructs as coherent and stand-alone scales (Schalast et al., 2008). The EssenCES Questionnaire (Schalast et al., 2008) has since been developed following extensive reviews and analysis of the WAS. It was developed as a brief measure to assess both patient and staff experiences of their therapeutic environment. This Questionnaire is a 17-item psychometric tool designed for assessing three core traits of the social and therapeutic atmosphere within forensic psychiatric wards. Therapeutic Hold is derived from the work of Carl Rogers (Rogers,

1951) and relates to the relationship between patients and staff as a feature of a therapeutic setting; Patient's Cohesion and Support derives from the therapeutic community literature and pertains to the experience and mutual support encountered by patients and staff; and Experienced Safety relates to Maslow's basic human needs of safety (Maslow, 1943) and incorporates the idea that a therapeutic milieu cannot be fostered in an environment that is oppressive or hostile.

This EssenCES Questionnaire has achieved a good degree of reliability and validity, demonstrating reliable and robust internal consistency, convergent validity and a coherent three factor structure. This questionnaire has been internationally validated as an instrument for assessing ward atmosphere (Howells & Stacy, 2007; Milsom et al., 2014; Schalast et al., 2008;) and has also been used to appraise staff and patient opinions of the therapeutic climate in both medium and low secure in-patient settings (Long et al., 2011), High secure services (Schalast et al., 2008) and approved premises (Davies & O'Meara, 2018; Davies et al., 2019). It is also regarded as a robust practical measure of treatment progress and responsivity (Long et al., 2011).

The exploration of social climate has been undertaken in a wide variety of settings including for example within high secure settings (Bowers, 2002; Bowers et al., 2006; Davies, 2004a; Schalast et al., 2008; Nathan et al., 2007), medium secure settings (Milsom et al., 2014; Tonkin et al., 2012), women's services (Fox et al., 2010; Howells et al., 2009) and approved premises (Davies et al., 2019; Shearman et al., 2015). Generally, it is suggested as being important in supporting the development and maintenance of a meaningful therapeutic culture for patients and a safe environment for staff within mental health services (Milsom et al., 2014). Specifically, Tonkin et al., (2012) investigated the relationship between social climate and staff perceptions of the working environment in a variety of secure settings and found that when staff view the environment as therapeutic, safe and supportive, staff have a more positive perception of their working environment. Similarly, a positive social climate is associated with increased motivation and engagement with treatment and more

positive therapeutic alliance (Long et al., 2011), greater trust between patients and staff (Fish & Culshaw, 2005) and reduced incidents of aggression (Ros et al., 2013).

However, it is also recognised that the role of the social climate has complications in custodial settings as well as in environments where professional supervision and risk management is a core factor to the environment (Davies, 2004b). This is especially pertinent within psychiatric or forensic settings where the daily atmosphere can often be a mitigating factor on individuals' perception of their own safety. The process of developing such environments has been found to be difficult with individuals with complex social, interpersonal and forensic needs as these environments can evoke strong feelings in staff and service users (Moore & Freestone, 2006). Notwithstanding, the ability to develop and maintain a meaningful therapeutic and social climate in both forensic and health settings has positive findings relating to increased treatment outcomes.

2.6 Interpersonal Relationships in the Therapeutic Process

The relationship that develops between an individual and those providing any therapeutic intervention is arguably one of the oldest (Rothman, 2007) and most important factors toward achieving positive outcomes from therapy (DeSorcy et al., 2016; Orlinsky et al., 2004; Ross et al., 2008). Rogers (1951; 2003) developed a client-centred psychotherapeutic paradigm where the core conditions of a therapeutic relationship are founded upon warmth, empathic concern, genuineness and unconditional positive regard and acceptance. These remain as the core components of any therapeutic process and underpin the process whereby the care provider and recipient of treatment work together in a collaborative, respectful, open and trusting relationship (Foreman & Marmar, 1985). This notion should also be reflected in any professional supervisory or supportive relationship, including within the criminal justice system and within approved premises.

Given that the social climate has been found to be a significant factor in therapeutic alliance (Long et al., 2011) it is important to define therapeutic alliance as one of the central components to the therapeutic relationship. Therapeutic alliance is defined as the collaborative aspects in a therapeutic relationship organised around the nature and purpose of that relationship (Horvath & Symonds, 1991). Similarly, and interchangeably, working alliance is regarded as an individual's ability to work purposefully within a therapeutic environment (Hoglend et al., 2011), and essentially, is related to a shared understanding of the purpose of the therapeutic work, a shared agreement on how to work together towards this goal and mutual trust and value of each other in the therapeutic process.

Bordin (1979) suggested that therapeutic alliance is the functional element of change in therapeutic relationships and is what makes it possible individuals to follow treatment effectively (Bordin, 1994). Bordin, over several revisions (Horvath & Greenberg, 1989) identified the three essential working components to working alliance, i.e. the agreement of goals, an agreement of tasks and the bond between therapist and client. Bordin's Model was latterly incorporated into the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986), and is regarded as the most widely used measure of therapeutic alliance (Ross et al., 2011) with a validated three factor structure (Tracey & Kokotovic, 1989). This model has three interrelated factors derived from Bordin (1979; 1994), namely the Therapeutic Task, the Therapeutic Bond and Therapeutic Goals, each of which are necessary for any functioning therapeutic relationship within a therapeutic culture. There are however a number of psychological assessment measures developed for appraising therapeutic alliance, for example the California Psychotherapy Alliance Scale (Gaston & Marmar, 1991), the Penn Helping Alliance Scale (Alexander & Luborsky, 1987) and the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983). Each of these measures share common themes, namely the relationship between patient and therapist, the experience of collaboration and support,

recognition of shared goals and objectives and the experience of the therapist as understanding and empathic.

Establishing a therapeutic alliance is regarded as a chief factor in engaging individuals with complex needs in a therapeutic process (Howells & Day, 2007) and has been found to be more integral to successful treatment outcomes than the treatment method itself (Safran & Muran, 2000). Therapeutic alliance has been shown to be essential to positive treatment outcomes in a variety of clinical setting (e.g. Burns & Nolen-Hoeksema, 1992; Connors et al.,1997; Gaudino & Miller, 2011; Prigatano et al., 1994) and within forensic settings (Blasko & Jeglic, 2016; Bovard-Johns et al., 2015; Kozar & Day, 2012; Yoder & Burton, 2015). For example, Clarke (2012) found that high levels of readiness to change at admission to treatment and high levels of therapeutic alliance at discharge were linked to better overall psychological functioning at discharge for treatment groups with mental health difficulties and co-morbid substance misuse difficulties. Cook et al. (2015) also found that alliance as viewed by the patient was more predictive of positive treatment gains than alliance viewed by the therapist in alcohol treatment interventions. This finding has also been replicated across a number of settings and with different psychological difficulties (e.g. Horvath & Symonds, 1991).

However, Kozar and Day (2012) suggest that there is currently insufficient evidence in the treatment literature to fully support the view that therapeutic alliance impacts either directly or indirectly on treatment outcomes, especially within forensic contexts. For example, Cookson et al. (2012) did not find that measures of therapeutic alliance were related to predicted incidents of aggression, suggesting that therapeutic alliance is not a strong correlate with treatment outcomes for men who demonstrate aggressive behaviours. Polaschek and Ross (2010) also found that measures of alliance did not predict how much meaningful change individuals made in reduction of risk of interpersonal violence. Similarly, other clinicians have found that alliance is not directly

related to treatment outcomes in more general clinical settings, where Hartley and Strupp (1983) found that early experiences of alliance predicted more positive outcomes in brief psychotherapy on a global level but not session by session. What is purported in the literature is that the repair of ruptures or a break-down in therapeutic alliance is as important as the relationship itself (Safran et al., 2011; Safran & Muran, 2000).

Tichenor and Hill (1989) suggested that working alliance is important as it serves as the platform for change but is not the mechanism for change in itself. This paradigm is important in thinking about how to conceptualise the notion of a therapeutic milieu and meaningful interpersonal relationships in therapeutic environments, especially where it is a social milieu as the predominant model i.e. within an Enabling Environment. The mixed findings about value of therapeutic alliance suggest that a number of other therapeutic and interpersonal processes are important in therapeutic relationships. More generally, therapeutic interventions that promote and encourage social support have demonstrated positive outcomes in many clinical treatments for a wide range of psychological difficulties (Drake, O'Neal, & Wallach, 2008; Rea et al., 2003; Shimazu et al., 2011). However, this is suggested to have not yet been broadly incorporated into forensic practice (Hawkins & Eddie, 2013). Marshall and Adams (2018) identify two salient themes that support therapeutic relationships to foster, and which help to moderate any difficulties experienced balancing safety and a therapeutic approach. These include an honest, open and respectful perspective and the importance of meaningful social processes when relating to others and communicating. Furthermore, the agreement of therapeutic goals (Long, 2001), the motivation to engage, readiness for treatment, interpersonal characteristics and the way that clinicians attend to and engage with patients are thought to be crucial ingredients to a therapeutic relationship (Kozar & Day, 2012).

Within a forensic context, social support is a known mediator of sexual offender recidivism (Andrews & Bonta, 2010), and high levels of self-confidence in staff members, a supportive staff team and good procedural security were perceived to be protective factors for understanding any risk of violence, alongside a reported positive therapeutic alliance between patients and staff (Allen & Beech, 2010).

Johnson and Haigh (2011) define meaningful therapeutic relationships as being curious about the needs of individuals and respecting their ideas and contributions. Haigh et al., (2012) suggests that investment in reciprocal social relationships in a therapeutic process enhances psychological growth, social learning and meaningful change. Elisha et al. (2013) identify that demonstrating an understanding approach underpins a therapeutic relationship; and genuineness, authenticity and the expression of empathy have been found to be important aspects (Cunningham, 2017), as well as feeling valued and without threat of rejection (Brookes, 2018).

What is pervasive amongst the literature is that the delivery of any therapeutic modality, particularly a psychosocial one places significant emphasis on the relationships between the patients and the clinical staff in their immediate surroundings (Blais, 2004; Johansson & Eklund, 2004). Furthermore, the quality of any therapeutic relationship is thought to be related to the degree of self-reflection and self-awareness by the staff offering the treatment and of those maintaining the therapeutic environment (Eliassen et al., 2016).

2.7 Understanding Personality Difficulties

The assessment and offer of treatment, including social and therapeutic milieu for individuals with psychological and personality difficulties should be wide ranging and holistic in nature (Byrt, 2013),

especially those who have committed acts of violence against others (Foster, 2001). Similarly, if working with individuals with such complex needs is not well managed and if individuals are unsupported, there is clearly established negative consequences to both psychological and emotional well-being (Elliot & Daley, 2012; Link et al., 1995; Scott, 2006). It is understood that attitudes towards individuals with mental health difficulties and personality disorder are commonly negative, characterised by pessimism and rejection (Bowers et al., 2006b; TNS, 2015). It is as such suggested that developing positive attitudes toward people with personality difficulties, improving the psychological understanding and enhancing self-management skills to better cope with the challenges of working with such individuals has positively impacted on effective practice in working with these complex clients (Bowers & Allan, 2006).

Carr-Walker et al. (2004) found that perspectives in working with personality disordered individuals differed between differing job roles within a high secure personality disorder treatment service. Notably, they found that Prison Officers differed to Psychiatric Nurses in their attitudes, where Prison Officer's attitudes were more positive overall, and that they report more liking for and interest in contact with prisoners, less fear and experienced helplessness, less anger and less frustration and they reported being more optimistic regarding treatment. Similarly, Kurtz and Turner (2007) investigated the experiences of staff working with individuals with personality disorder within medium secure psychiatric services using qualitative methodology. They found that staff identified that their role was complex and multifaceted and there were conflicts derived from an unsympathetic view of personality disorder from society (as well as from others within the same hospital). They also found that staff had a strong desire to have a genuine and compassionate relationship with their clients, they experienced collaboration and support from their colleagues and a recognition that an and transparent communication was paramount. Importantly, it was also noted that staff often felt physically safe in this environment but emotionally vulnerable, and that

staff described that it was important to feel connected to others within the healthcare structure because there was also an experienced risk of isolation from other key professionals.

Evidence tells us that effective clinical outcomes for working with individuals with personality difficulties is heavily dependent upon agreement of goals and outcomes for treatment (Davidson, 2008; Tyron & Winograd, 2011), effective treatment planning and evaluating outcomes (Swift & Callahan, 2004; Wood & McMurran, 2013). Similarly, the safety of staff working with such individuals with complex needs and/or personality disorder, and the efficacy of any therapeutic processes in these environments depends upon the psychological wellbeing and support of staff (Farquharson, 2004). This is because staff responses to difficult and challenging behaviours can often include hostile attributions, negative perceptions of behaviour and perceptions of manipulativeness and uncooperativeness, and this can result in withdrawal and dismissive attitudes (Bowers et al., 2006; Lewis & Appleby, 1988; May & Kelly, 1982). For example, Shefer (2010) found higher perceived levels of stress are reported by staff in a prison based therapeutic community because of the close day to day therapeutic relationships with the residents, potentially as a result of staff responding to some demonstrated challenging behaviours (e.g. deliberate self-harm or violence), and with the negative interpretations of this behaviour (Lewis & Appleby, 1988). If this process is repetitive, staff are suggested to engage in reciprocal patterns of attributing negative or critical intent to the actions of patients which can result in rejection or confrontation to the interventions, perhaps further exacerbating a perception that their behaviour is divisive or manipulative (Bowers, 2003). Shine (2010) suggested that some success has been demonstrated in managing and treating individuals with complex needs and personality disorders within therapeutic communities. They however found that individuals with more complex difficulties often drop out more frequently and demonstrate greater therapy interfering behaviours. Similarly, Zhang et al. (2011) found limited impacts on recidivism with individuals released from a prison-based therapeutic community after five years when compared to matched controls.

Bowers (2002) purported that staff who demonstrate a positive attitude to difficult and complex patients report lower levels of stress, greater emotional well-being at work, and a more positive perception of their relationship with their patients. They also suggest that nurses with more positive attitudes interact more with their patients, are less likely to be involved in incidents of conflict with them and are suggested to be able to perform better at their job. Similarly, Bowers et al. (2006) found that a more positive attitude to personality disorder was associated with a greater sense of personal well-being, less stress and burnout and better job performance. They also suggested that in order to create and maintain a positively functioning environment in working with complex and challenging behaviours requires constant review of the attitudes to interpersonal difficulties, there should be a constant focus on the management, education, supervision and support of staff, as well as consideration to how staff are selected to work in such environments. This is further supported by the views of Ward et al. (2003) who indicate that the culture of the organisation, of the staff working within the organisation, the experience of these individuals within the setting and the relevance of their knowledge of such environments impacts effective clinical practice.

It is understood that people working in emotionally challenging environments, including working with challenging behaviour and with people who harm themselves can struggle with negative emotional consequences, for example compassion fatigue, apathy and alienation (Dickinson & Hurley, 2012). Similarly, stress is common in working with individuals with challenging behaviour and personality difficulties which can result in burnout and detrimentally impact the quality and stability of treatment services (Sorgaard, 2007). Drawing on System Theory (Bowen, 1978), Dallos and Draper (2010) argue that once negative relationship patterns exist in a given setting there is a reactive tendency within the system itself that can also cause further dysfunction. This reflects the notions of ‘parallel processes’ that have been identified in environments that involve therapeutic relationships with individuals with complex needs, especially with those who are interpersonally violent (Polen, 2010). Parallel processes are a psychoanalytic concept that also describes staff

relationship dynamics paralleling or reflecting the relationships and experiences between service users (Searles, 1955). An example of this might be where staff in an approved premise are experiencing threat and hostility from residents and then respond to this by being abrasive, confrontational and rigidly enforcing rules and boundaries without consideration to the function of the residents' behaviour. This then in turn may create further discord by the residents and further hostile behaviour.

The research literature also indicates that exposure to social conflict and aggression are known to compromise staff well-being (Kelly et al., 2016). Foster (2001) asserted that staff persistently faced with anxiety in relation to working with those who have personality difficulties and those who have committed acts of violence may need to defend themselves against aspects of their emotional experience in order to preserve their own mental health to continue working professionally. What is evident in the research in working with complex individuals with forensic needs is that both procedural and relational security are integral to the safe and effective functioning of such environments especially where there are therapeutic goals (Kennedy, 2002; NHS, 2014; Reed, 1997). Procedural security is defined as the structure of having policies and procedures, routine and organisation in order to allow for confidence in practice and ensure consistency (Reed, 1994; 1997). It is also similar to the concept of Organisational Containment defined by Ruch (2005). Relational security however is defined as the practical and clinical knowledge and understanding we have of individuals that informs the effectiveness of therapeutic relationships that have a purpose and with understood limits (Appleby, 2010). Furthermore, relational security is suggested to also be related to the containing experiences offered by staff in the therapeutic relationships and the capacity for these attachments to be used to psychologically understand and engage with an individual responsively. For example, Adshead (2004) suggested that in emotional containment, it is the attachment relationships themselves that are used to impact emotional arousal and in the process of helping individuals to think about their own minds and the minds others.

Establishing a secure base, akin to that defined by Ainsworth in parenting (Ainsworth, 1967) is suggested to be an essential task of those working within forensic settings with individuals with complex needs, especially in the setting and maintaining of physical and interpersonal limits and boundaries (Aiyegbusi, 2004a). These are also identified as being the core elements of the process of emotional containment within such settings (Adshead, 1998). Although defined in the psychoanalytical context by Bion (1961), Aiyegbusi (2004b) defines containment as the process of understanding the difficult behaviours presented by patients and being able to understand and tolerate these so that the patients themselves can learn to understand how they are feeling and behaving. Thus, the process of containment in working with individuals with complex mental health difficulties is essentially a process of staff making sense of the distress and then communicating this understanding back to the person so that there is a shared understanding of the difficulties. More, powerfully the containing experience is suggested to be derived from the interpersonal and therapeutic relationship in which this interaction happens, and by the clinician's ability to genuinely and authentically engage the person who is in distress. This is fundamental to the notion of effective relational security, therapeutic alliance and culture.

Boundaries are integral to therapeutic relationships and establish both an interpersonal and practical balance between staff and service users (Kennedy, 2002). Establishing clear and robust professional and interpersonal boundaries allows for staff to set limits, provide structure, provide containment and create an atmosphere of safety that allows individuals to reflect on their experiences (Hamilton, 2010; Knapp & VandeCreek, 2012). This is salient as previous literature informs us that when clinicians are unclear or lacking in confidence about social and interpersonal, and indeed professional boundaries their experience of certainty, safety, and predictability can be negatively impacted (Appleby, 2010; Budge, 2016). Safety from threat can also be achieved in a number of other ways, for example having a well-led staff team who understand the key principles of the regime and how the team can be responsive to the risks and needs of the residents (Latessa

& Lowencamp, 2002). Trust is also regarded as a scaffold needed for effective relationships to develop within forensic settings (Askola et al., 2017; Cleary, 2003), and alongside relating to others without judgement (Gildberg et al., 2012; Thorpe et al., 2009), taking a genuine approach to relationships has been found to be supportive of meaningful therapeutic relationships in forensic settings (Brunt & Rask, 2013; Rask, Brunt, & Fridlund, 2008; Schafer & Peternelj-Taylor, 2003).

Individuals with psychological difficulties do not often actively seek help (Bland et al., 1997), and this is exacerbated within forensic settings where individuals can often feel pressured into engaging with services (Day et al., 2004) potentially because of criminal justice requirements. There is therefore a need for clinicians to both support and offer care to individuals whilst also holding in mind their willingness to adhere to such interventions and the expectations of the providing service. What is evident in the literature is the importance of the recognition of the dual roles staff members have when offering therapeutic and risk management frameworks in forensic settings (Hamilton, 2010; Marshall & Adams, 2018). A balance must be accomplished between custodial and relational behaviours (Martin & Street, 2003) but this process of managing risk and relationships is often a dilemma faced by staff fraught with difficulties, including within approved premises (Mason et al., 2008; Castledine, 2016). The polarity of these perspectives has been observed for many years, initially in the definition of 'security' versus 'care' in forensic settings (Home Office, 1975) and in the notions of the 'split' in psychoanalytic literature (Green, 2018), especially that defined as being salient in response to aggression (Kernberg, 1992). Splitting is characteristically defined as different behaviours expressed about a group of individuals with a staff team becoming organised into groups with opposing perspectives (Gabbard, 1989; Green, 2018). This often causes conflict amongst staff, differential treatment of the patients and a reduced effectiveness of therapeutic relationships.

Clarke (1996) undertook an unorthodox and unconventional covert study observing nursing staff within a secure forensic therapeutic community without their awareness. Through these observations two discreet views of the staff teams emerged, those who were 'controllers' and those that were 'carers'. It was observed that 'controllers' often openly criticised 'carers' and they viewed aggression as acts to be dealt with; whereas 'carers' tended to view aggression as resultant of the context and environment. Controllers were unable or unwilling to voice any therapeutic approaches to engaging with the patients whereas carers were. They also held value in therapeutic activities where controllers did not. Importantly, both 'controllers' and 'carers' were observed to demonstrate suspicion of each other; they both accepted the need for relational and procedural security, but with the 'controllers' more focussed on containment of risk; and are suggested to reflect what they thought the wider society wanted from forensic healthcare. This study is highly subjective, it represents one sample, the data collection methods are questionable and no reporting of the analytical or interpretative methods is given. Notwithstanding, it exemplifies the presence of polarities that are often experienced by staff teams in working within secure forensic settings.

Trestman (2017) suggests that there are many interrelated factors necessary for a safe space and the reduction of aggression. Gildberg et al. (2010) reviewed the literature in forensic settings and found that patients and staff perceive that there are two key views on staff-patient relationships; a 'paternalistic and behaviour changing care' and 'relational and personal quality depending care'. The former incorporates control, rules, structure and parenting-type behaviours as the means to manage safety from threat through controlling and observing, setting limits and enforcing rules, and supporting patients practically (Hinsby & Baker, 2004; Rask & Aberg, 2002). Often the strategies used to maintain predictability and safety is to focus more rigidly on rules, boundaries and managing problematic behaviours through a lowered tolerance to threat and enacting consequences to difficult behaviours (Alexander & Bowers, 2004; Bowring-Lossock, 2006; Clarke, 1996; Hinsby & Baker, 2004; Meehan et al., 2006).

The latter (i.e. personal quality approaches) is emphasised by the meaning given to and value in the interpersonal relationships as the components of a relational approach. This is characterised by personal qualities offered by the staff, interpersonal engagement and support with social activities. Strategies to maintain safety here might include supporting individuals practically and helping them solve their own problems, but this is suggested to occur best within an organised environment, where staff are able to impose controls and limitations where necessary (Moos & Houts, 1968; Schalast et al., 2008).

The Boundary Seesaw Model (Hamilton, 2010) also helpfully defines common individual and systemic responses to conflict and challenging environments, as well as the underlying emotional and behavioural processes. It is conceptualised as a 'seesaw' to emphasis the gradual shifts that can occur in these relationships when one theme of relating to service users gathers more weight. This model defines three relational qualities, the 'Controller' and the 'Pacifier' as problematic modes of relating; and the 'Negotiator' as a healthier balance. The Negotiator is defined as there being a presence of healthy boundary management with a balance of care and control and where risk and anticipated threat is contained through flexible but firm interpersonal boundaries supported by a healthy professional and therapeutic relationship. Those expressing this mode are often regarded as being open, thoughtful, contained and who have a clear understanding of what boundaries can be flexible when needed and which cannot.

Regarding unhealthy modes, the characteristics of the controller are described as being judgemental, controlling and fastidious about rules, procedure and risk management. These are beliefs consistent with a view that safety that can be only maintained through control and rigid boundaries, and the response to pushing boundaries is to enforce them more tightly. There is as such little identification with the therapeutic processes or with relationships, and a tendency to have a social and emotional distance from the patients. In contrast, the Pacifier mode is activated

when individuals are overly accepting, acquiescent to others' needs, self-sacrificing and where relationships can become overly focussed on managing the patient's needs. There can be the expression of unconditional care and urges to rescue. There is also a position taken that safety from threat can often be best managed by increasing the flexibility of their boundaries which then can become unconditional. These 'pacifying' responses also parallel 'yielding' strategies, which are essentially conflict avoidance strategies identified by Van der Helm et al. (2011) in their experiences of working in secure residential accommodation (i.e. equivalent to an approved premise) in Holland. These yielding strategies are defined as a fear-related maladaptive coping strategy to perceived or experienced threat that are submissive in nature and constitute giving in or acquiescing to the person offering the threat. These strategies are suggested to be ineffective as they have been found to lead to indirect aggression from residents.

These concepts of how individuals themselves, and as part of a wider team system manage conflict, threat and a lack of safety within their environments is especially pertinent with the increasing recognition of individuals with complex needs and personality difficulties within approved premises. This is because the ability to understand, formulate and maintain professional and therapeutic boundaries enough to deliver a therapeutic environment or relationship is a difficult process. Expertise to do this is often derived from professional and clinical training (Hamilton, 2010). However, the dilemma often faced in forensic settings is that those on the 'coal face' delivering the therapeutic processes and enforcing the boundaries are often unqualified staff members who are expected to navigate a complex and ambiguous clinical activity.

2.8 Developments in Psychologically Informed Environments

Psychologically informed environments are specific environments where staff members have additional training to develop an increased psychological understanding of their work (Bainbridge, 2017). This understanding "enables them to create an enhanced safe and supportive environment which can facilitate the development of those who live there" (Turley et al., 2013 p. 2). The focus is on the quality and nature of the interpersonal interactions and relationships with the staff and residents of these environments, and in the process of nurturing a sense of belonging, purpose and achievement to reduce re-offending and improve psychological well-being which is achieved through the quality of the interpersonal relationships and the shared goals (e.g. Brown, 2014; Turley et al., 2013).

It is recognised that there is a need for innovative interventions to reduce offending and increase staff confidence in working with individuals with complex needs (Bruce et al., 2017). Although there is no set formula for developing a psychologically informed environment (Johnson & Haigh, 2010), Turley et al. (2013) define four key areas to developing such an environment, i.e. a Psychologically informed environment. These are (1) having respectful and genuine interactions with both staff and residents where staff are available and dependable and work collaboratively with the residents; (2) promoting support, collaboration and mutual encouragement between residents; (3) promoting autonomy, collaboration and involvement of residents where possible in the structure and decision making of the environments; and (4) the availability of group and individual support structures to develop and foster meaningful relationships with professionals. Robust training is crucial to ensure ethical, effective, and consistent programme delivery and support, and supervision is essential for effective service delivery. These notions help staff to maintain high standards of delivery (Turley et al., 2011) as well as helping the teams to stay resilient (McNaughton Nicholls et al., 2010). Furthermore, Brown (2014) outlines the key importance of attending to the psychological processes

both between staff and residents, and from a service and an organisational perspective. Brown argues that understanding the function and nature of the psychological relationships in such environments is an important element of the psychological containment for both offenders and staff. When this has been observed significant improvements in institutional behaviour have been observed (Bainbridge, 2017; Bettles et al. 2015).

Importantly, the notion of pro-social modelling is thought to be important within psychologically informed environments, especially those within a forensic framework. Trotter (2009; 2010) outlines this concept as being related to the appropriate demonstration of collaborative problem-solving, modelling pro-social values and what constructs a pro-social influence. This has been found to be important in managing risk related behaviour in forensic contexts (Listwan et al., 2006), integral in therapeutic alliance (Trotter, 2010) and a key skill in the supervision of offenders (Trotter, 2009). This is especially so in approved premises where the need for any therapeutic environment is to try to recreate the roles of an individual's social relationships within such an environment with the wider social structure (Schoenholtz-Read, 2001), as well as how that system itself exists within a wider social structure (Knobloch & Knobloch, 1979).

The Enabling Environment initiative was developed by the Royal College of Psychiatrists' Centre of Quality Improvement (CCQI) which is essentially a clinical practice development forum that connects directly with clinicians and that encourages healthcare providers to take responsibility for improving local mental health services. The Enabling Environment initiative was first developed in 2009, based upon the work first undertaken in 2002 by the Community of Communities Quality Network, governed by the UK Royal College of Psychiatrists. This developed and implemented a set of standards by which therapeutic communities operate (Johnson & Haigh, 2010; Royal College of Psychiatrists, 2010). The work undertaken by the Community of Communities quality network fostered the development of a model termed a Psychologically Informed Environment (PIE),

envisaged to support the distress relating to individuals and staff working with such individuals when they are made homeless.

Johnson and Haigh (2010) identify that a PIE is an environment developed "to allow the resources and the day-to-day functioning of the service to be focused on addressing the psychological needs and emotional issues thrown up by the residents" (p. 2). Developmentally, following the implementation of such PIE's, work with Offender Mental Health Teams at the Ministry of Justice and the Department of Health (e.g. Rutherford, 2010) led to the development of Psychologically Informed Planned Environments (PIPE's). A PIPE is defined as "a safe and supportive environment to help the development of offenders, to focus on the environment in which the offenders operate, help them recognise relationships and interactions, and their importance, and to approach situations in a psychologically informed way" (Turley et al., 2013 p. 5). Both the PIE and the PIPE therapeutic cultures are "directed towards institutions that need to recognise the psychological and emotional aspects of their work with greater clarity and sensitivity, and to adapt their ways of working accordingly" (Johnson & Haigh, 2011, p. 18).

From these environments, the concept of an Enabling Environment has grown to be applied to contexts where a therapeutic space, culture or milieu are salient ingredients to change and are foundations to developing psychological well-being, but where these are suggested not to be formal therapeutic communities or formalised treatment environments (Johnson & Haigh, 2011).

An Enabling Environment is underpinned by a number of psychological and psychosocial therapeutic paradigms, including attachment theory (e.g. Bowlby, 1969), group theory (e.g. Bion, 1961; Foulkes, 1964), containment (Bion, 1962; Winnicott, 1956) and therapeutic community literature (e.g. Haigh, 1999; 2013). In essence, the concept of an Enabling Environment is to generate a climate or organisational 'space' to allow staff to be able to foster an interpersonal or

'relational' ethos, as well as an 'experiential' ethos, i.e. a reflective and socially and emotionally empowered culture that fosters a compassionate and responsive treatment or therapeutic culture. It allows for a more psychologically based understanding of difficult behaviours in a psychological way (Turley et al., 2013). This is all extant within an organization that also meaningfully contributes to a sense of safety and supportiveness of the environment. An Enabling Environment is therefore fundamentally underpinned by the concepts of both a PIE and a PIPE, by social climate (e.g. Moos, 1997; Schalast, 2000) as a therapeutic milieu, and the literature that underpins therapeutic communities (Johnson & Haigh, 2011).

An Enabling Environment is founded upon the hypothesis that a socially therapeutic milieu underpinned by quality reciprocal social relationships enhances psychological growth, social learning and meaningful change (Haigh et al., 2012). The College Centre for Quality Improvement (CCQI, 2013) state that, "the standards for Enabling Environments deal with essential human values and, taken as a whole, they outline a flexible and adaptable framework which can be integrated into the practice of a wide range of environments in order to improve relationships and well-being for all involved" (p. 3).

The evaluation of therapeutic climate has been undertaken in a wide variety of settings (e.g. Castledine, 2015; Davies, 2004a; Haigh et al., 2012; Howells & Stacey, 2007; Nathan et al., 2007; Schalast et al., 2008), but the evaluation of Enabling Environment cultures in forensic settings or in approved premises has yet to be fully undertaken. Schofield and Williams (2015) identify that being an effective Enabling Environment improves productivity in the environment, reduces staff absences and turnover and reduces incidents in high risk environments such as prisons and secure units. Likewise, Turley et al. (2013), in their pilot evaluation of PIPE environments found that the therapeutic culture increased positive relationships between prisoners and between prisoners and staff; prisoners felt more supported and understood; prisoners indicated that they felt more able

to manage impulsive and confrontational behaviours; and that they found the environment conducive for learning and consolidating their previous treatment. As an Enabling Environment is underpinned by the PIPE ethos, we would expect similar underlying psychosocial benefits. Similarly, these therapeutic environments have been found to be more effective in managing complex individuals (Turley et al., 2013), for example, developing positive attitudes and improving the psychological understanding of people with personality difficulties enhanced the capability of staff to deal with the challenges of working with such people (Bowers & Allan, 2006).

An Enabling Environment is not a treatment intervention, it is a social therapeutic culture or milieu that is based on the premise that the way staff interact with offenders can impact their psychological and social progress (Bolger & Turner, 2013). The principal values include the notion that the nature and quality of relationships is central to the work undertaken in such environments, that all behaviour is regarded as a form of communication, that everything is seen as a learning opportunity, that service users and staff need to take responsibility for themselves, others and the environment and that risks can be taken within a network of strong and trusting relationships (Schofield & Williams, 2015). An Enabling Environment therefore reflects a good practice environment, shared values and approaches, and collaborative agendas about the provision of an effective and meaningful environment. It also offers the opportunity to recognise and praise good and effective practice in action. This environment is underpinned by the relationships between people, where responsibility, accountability, involvement in the environment and creativity are promoted and encouraged. Also, decision making is shared and transparent, people are valued and supported, and all behaviour, including that which is disruptive is viewed in a meaningful way as a communication to be understood (Haigh et al., 2012).

The Enabling Environment initiative focusses specifically upon ten factors; good communication, boundaries, belonging, involvement, development, safety, structure, leadership, empowerment and openness (Johnson & Haigh, 2010). These are defined below (NHS, 2020);

Belonging	The nature and quality of relationships are of primary importance
Boundaries	There are expectations of behaviour and processes to maintain and review them
Communication	Everyone is supported to communicate in ways that enable them to l listened to and heard
Development	There are opportunities and support for self-development and growt
Involvement	Everyone shares responsibility for the environment
Safety	There is support in place to help everyone feel emotionally safe
Structure	Engagement and purposeful activity is actively encouraged
Empowerment	Everyone is encouraged to develop their personal Autonomy
Leadership	Leadership takes responsibility for developing and maintaining an enabling culture
Openness	The environment is outward-looking and open to learning

Essentially, it is a process whereby communities can be empowered to practice in this way to provide a place of belonging where the nature and quality of relationships are of primary importance (Brookes, 2018). To become an Enabling Environment, each institution develops a portfolio that is assessed and graded. There is not however a consistent way that this is currently achieved (Davies et al., 2019). The Enabling Environments Award reflects an accomplishment for those who can demonstrate they are achieving an outstanding level of best practice in creating and sustaining a positive and effective social environment (CCQI, 2018). Implementing the Enabling Environment standards within an approved premise requires what is regarded as a "whole systems approach to implementation, thus everyone within the site (both residents and staff) needs to be engaged as active participants" (Davies et al., 2019, p. 222).

The Enabling Environment process is embedded in the National Offender Management Service (NOMS) Offender Personality Disorder Pathway (NOMS, 2015) and began to be applied to approved

premises in early 2014. This study therefore explores the experiences of staff within three approved premises as they engage in the Enabling Environment initiative between 2017 and 2019. The research investigates the nature of, the processes involved in and the therapeutic functions of a newly developing therapeutic environment within approved premises. It will compare and contrast these findings to expert opinions on Enabling Environments, and it will also aim to define the culture and milieu as it exists and may change over time. Finally, an understanding and explanation of the social and relational complexities of working with residents demonstrating complex needs within the psychologically informed framework termed an Enabling Environment will be presented.

Chapter Three
Overview of Q Methodology

3. Q Methodology

3.1 What is Q Methodology

Q-Methodology was developed by Stephenson (1953) in the early 1930's and has become a well-established, empirically validated approach to study opinions, attitudes, discourses and beliefs (Brown, 1980), i.e. subjectivity (Watts & Stenner, 2012). Subjectivity is defined as how people conceive and communicate their views about a subject topic (McKeown & Thomas, 2013) and subjectivity is best observable when people identify and communicate their thoughts, beliefs, attitudes and values about a given subject (Paige & Morin, 2016). Q Methodology therefore is a means to explore the subjectivity of people's experience to attempt to explain, from the point of view of the participants, the shared perspectives around a theme in focus (Watts & Stenner, 2005; 2012). The key concept within Q Methodology is the notion of investigating what is termed 'operant subjectivity' (Stephenson, 1953), i.e. the relationships between the participant's views on a topic. This is obtained through the factor analysis of the Q-Sorts which indicates functional distinctions between viewpoints as opposed to logical distinctions as found in R methods (Brown; 1993; Ven Exel & De Graaf, 2005). Brouwer (1999) calls these 'aspects of mutual coherence'.

Q Methodology uses an adapted form of a factor analysis to explore the patterns of subjective views as opposed to variables within a data set (Watts & Stenner, 2012). In Q Methodology the common viewpoints shared by people are explored (Risdon et al., 2003) to identify groups of participants that make sense of a theme or topic in comparable ways (Watts & Stenner, 2005). Where R Methodology is used to describe a population of people that share common views, Q Methodology explores the correlations between participants. It does not test the participants themselves or

impose any a priori meanings and the participants themselves are asked to decide what is meaningful and significant from their perspective (Coogan & Herrington, 2011). Similarly, Q Methodology differs meaningfully from using a questionnaire or psychometric assessment-based research design as these often have researcher imposed or empirically imposed categories that guide the responses by participants. Q Methodology inverts this process and the analysis identifies categories that are operant, i.e. that are functionally meaningful viewpoints shared by and identified by the participants.

Q Methodology was derived from the need to move away from the logical statistical testing of data (i.e. R Methodology) that explores hypotheses and generalises results to wider populations. It was developed to make sense of complex social contexts from the perspectives of those involved but does not do so in a way that breaks down the data into thematic concepts as might be commonly found in other qualitative methods (Watts & Stenner, 2005). What is unique about Q Methodology is that it allows the data in the form of "constituent themes" (Watts & Stenner, 2005, p. 70) to be described and presented as representations of how they are interconnected and related to by groups of participants. The study of subjectivity is the core aspect of Q Methodology as opposed to the pursuit of objectivity, which is the driving force behind R Methods.

Q Methodology is regarded as a 'Qualiquantilogical' methodology (Stenner & Stainton-Rogers, 2004), i.e. a mixed method research design as it integrates many of the aspects within qualitative research with the ability to apply the statistical analyses found within quantitative methods (Newman & Ramlo, 2010). It therefore allows for a systematic and rigorous way to examine subjectivity (Nicholas, 2011), although it is not a standardised psychometric process. It is described as a means to explore participants' subjective views, allow these views to be expressed idiosyncratically to allow for the drawing out of the subjective opinions of participants (Brown, Durning, & Selden, 1999).

Q Methodology has received criticism because it is a process of exploring the subjective perspectives of participants by using statements that are essentially untested and not empirically validated (Van Exel & de Graaf, 2005). This is suggested to have implications on both the test-retest reliability of the methodology and on the ability for the findings to be generalized to the wider population. Here, Brown (1980) suggests that there will always be a finite number of perspectives around any given topic, and therefore a well-structured Q-Study that has robustly explored the topic of investigation and developed a representative Q-Set will be able to identify these viewpoints. The notion of operant subjectivity also helps to reduce the salience of these criticisms as the underlying function of Q Methodology is to identify the functionally meaningful perspectives and viewpoints of the given participant population about the given subject field, rather than identify the number of people in the general population that adheres to or identifies with these viewpoints and perspectives.

Furthermore, Q Methodology as a method has been found to have a high test and retest reliability, with high correlation coefficients being found, e.g. of 0.80 (Brown, 1980; cited Akhtar-Danesh et al., 2008) and 0.86 (Watts, 2009). As a result, this method has been used to obtain and qualify the subjective perspectives of participants in a wide variety of areas, including nursing (Valenta & Wigger, 1997), mediation (Brown-Walker, 2013), communication science (Stephen, 1985), terrorism (Kocak, 2011), health psychology (La Cour, 2012), the psychological treatment for depression (House et al., 2017) and personality disorder (Dean et al., 2018).

In essence, Q Methodology is a research methodology whereby participants rank order set statements about a particular concept or subject into a set distribution in order to identify the similarities and differences in subjective opinions around the given subject topic. This process is done in a first person or subjective process where each statement is ranked relative to each other. The statements ranked higher have a greater significance to that individual, and vice versa. These

can then be investigated as a collective of sorts within a cohort at one time point, or as a time series design as is explored with this study.

3.2 Conventional and Time Series Q Methodology

There are two basic design types of Q Methodology, namely single-participant designs and multiple participant designs. In single-participant designs, **t**he participant undertaking the Q sort is the subject of the analysis and usually the same Q-Sorts are completed under a number of different conditions of instruction. The idea behind this is that analysing the multiple Q Sorts create a more all-inclusive view of the perspectives held by the individual (Brown, 1991) and reveal an amalgamation of the issues related to their subjective self-perspective (Watts & Stenner, 2012). Q Methodology however is predominantly used to assess cross sectional subjective experiences amongst a participant group and allows these to be interpreted for the relatedness of the perspectives of the participants (Watts & Stenner, 2012) at a time point.

There is an established empirical basis in the literature outlining how Q Methodology has been robustly used to explore experimental and quasi-experimental repeated measures designs from which this study draws its structure. As such it is a methodology that can be used in a time-series process, although Q Methodology is not conventionally a test of difference (Watts & Stenner, 2012). The perspectives of two different groups can be meaningfully statistically compared after the initial analyses of each group has been completed using theoretical and statistical comparisons of each group and individual members between times (Watts & Stenner, 2012). Importantly, because changes in perspective are generally not significant in such study designs, methods exists to determine whether changes over time are significant enough to reveal prominent differences based upon the research questions (Expositor, 1992).

This current study involves a research design using multiple participants in a time series or repeated measures design, and involves a representative sample from within a specific environment, namely an approved premise. As such, Watts and Stenner (2012) suggest that Q Methodology studies are well suited to explore the specific perspectives of a specific set of people, or the viewpoints found within specific institutions. A number of key examples are published where Q Methodology has been used to explore a time-series design within a representative sample, including within learning outcomes in a health care setting (Gaebler-Uhring, 2003); within investigating outcomes of an intervention implemented in higher education (Popovich et al., 2003; Wilson, 2007); in the investigation of the impact of mediation training (Brown-Walker, 2013). Furthermore, this same design has been used in the investigation of professional practice learning within psychotherapy training (Ablon & Jones, 1998; Bambery et al., 2007). Similarly, more general repeated measures designs have been used to explore shifting political attitudes (Freie, 1997); perspectives towards environmental and social policies (Pelletier et al., 1999); and influentially within Q Methodology, Block (2008) who investigated personality characteristics across time.

Embedded within the repeated measures design, this study also draws on the analytic process of using what is regarded as a 'prototype' or gold standard card sort for correlational comparison with the card sorts of the participants throughout the time series. This analytic methodology is thought to add an additional component in the analysis of time-series data as correlations to the 'prototype' can be undertaken at each stage of the longitudinal study to ascertain any changes to the way people subjectively view a topic. The use of a 'prototype' or ideal Q-Sort for comparative analysis has been demonstrated and robustly field tested through Q studies. For example, it has been used in comparing ideal representations of Nursing Practitioners (MacAndrew & Elliott, 1959) and in the evaluation of Trainee Psychotherapists Ablon and Jones (1998) and Bambery et al. (2007).

3.3 Q Methodology Terminology

Undertaking Q Methodology requires an understanding of the theoretical and mathematical principles behind the method and the analysis. It also requires the understanding of some more unique terms and definitions. The most common terms used are defined below in Table 1 and are taken from McKeown and Thomas (1988) and Watts and Stenner (2012);

Table 1. Terms within Q Methodology derived from McKeown and Thomas (1988) and Watts and Stenner (2012).

Terminology	Definition
Concourse	The discourse, commentary, shared perspectives and themes surrounding a given topic or subject area, e.g. ordinary conversation, commentary and discourse about everyday life and relevant literature. The Concourse should be representative of the full spectrum of opinions on a given subject.
Q-Set	These are defined from the Concourse and are a set of statements used as the stimulus items in the actual Q-Sort. They are statements usually presented as cards to be sorted and placed in rank order on the Card Sort Table.
Source: Naturalistic	Statements are derived from oral and written sources such as transcripts of focus groups or interviews. Often the focus groups or interviews are undertaken specifically for the development of the Q-Set.
Quasi-naturalistic	Statements are also derived from secondary sources external to the study, for example literature related to the Concourse and focus groups or interviews from people who are not involved in the sorting of the statements.
Ready Made	Statements previously standardised and validated or developed from other sources not within the Concourse, i.e. psychometric questionnaires or questionnaires.
Structure: Unstructured	Where a selection of statements are chosen that attempt to be a representation of the Concourse as a whole without concern for the theoretical constructs that underpin them.
Structured	Where the Concourse is broken down into sub themes or concepts through a predetermined theoretical framework with

	the aim of finding a representative sample of the larger Concourse.
P-Set	The participant groups.
Theoretical	A theoretical sample are chosen specifically for the purpose of the study with the premise that they will hold different / similar viewpoints about the subject topic.
Random	A random sample is also known as an opportunity sample and may reflect participants chosen for their general connection to the research topic.
Extensive	An Extensive sample is one where the group of participants sort the Q-Set under the same conditions of instruction. This can be undertaken at one time point or multiple sorts under the same instruction over a given time period.
Intensive	An Intensive sample is one where the participants are requested to sort the Q-Set under multiple different conditions of instruction. This can also be undertaken at one time point or multiple sorts under the same instruction over a given time period.
Single Case Study Design	A single case study design is where one participant undertakes a sort of the Q-Set at different timepoints, either using the same conditions of instruction, or different conditions of instruction.
Q-Sort	The process whereby the participants sort, organise and rank order the statements on a pre-defined distribution, usually on a prepared Card Sort Table using specific conditions of instruction.
Distribution: Numbering	The numbering of the dimensions on which the statements must be sorted needs to indicate extremes of positive and negatives on both ends, with the middle of the distribution reflecting the items of lower or neutral importance. The number of statements in a Q-Set reflects the number of participants and the representative nature of the Concourse.
Naming	The naming of the dimensions on which the statements must be sorted, usually ranging from 'most important to least important' or 'most agree' to most disagree'.
Range	The range of the distribution is related to the number of statements in the Q-Set, e.g. a nine-point (-4 to +4) distribution for 40 items or less, an 11-point (-5 to +5 distribution for 40-60 items), and a 13-point (-6 to +6) distribution for sets of 60+ items
Slope / Kurtosis	The kurtosis of the distribution depends upon the process of the distribution, the conditions of instruction and the research

	questions (Brown, 1980). The usual kurtosis follows a normal distribution.
Conditions of Instruction	The specific instructions that the participants follow to sort the Q-Sort Cards that contains the context for how they rank order each statement when sorting the Q-Set.
Q-Sort Cards	The physical cards used within a Q-Sort that have the statements printed on them.
Card Sort Table	Usually an A1 sized piece of card that helps to facilitate the participant to sort and rank order the Q-Sort Cards. This has defined spaces for the placement of the Q-Sort Cards based upon the agreed distribution, shape, range and kurtosis of the sorting process.
Post Card Sort Interview	A semi-structured interview process whereby additional qualitative data can be gained about the participant's undertaking of the Q-Sort. This usually explored the thinking and rationale behind why the participant ranked the statements at the extremities of the distribution.

3.4 Implementing a Q Study

Brown (1980) identified five steps to implement a Q Methodology study. The steps include:

1. Identifying a Concourse
2. Developing the Q-Set
3. Specifying the P-Set
4. Administering the Q-Sort
5. Conducting data analysis.

3.4.1 Concourse

A Concourse is the methodological and exploratory process whereby the statements used within the Q-Sort (i.e. Q-Set) are derived and defined. It is no "more or less than the overall statements from which a final Q-Set is sampled" (Watts & Stenner, 2012, P. 34). The process of undertaking the Concourse is to systematically review all the available information from as diverse and varied sources as is possible for the purpose of identifying all the possible statements that might represent that subject matter or topic under investigation. Watts and Stenner (2012) suggest that the final Q-Set will be determined by the subject matter in the Concourse and the full nature of the Concourse becomes apparent when contained within a research question and context of a research study (Watts & Stenner, 2012). Watts and Stenner (2005) suggest that it is when the participants are actually sorting the statements that the statements begin to have any meaning, i.e. operant subjectivity for that population about the subject topic.

McKeown and Thomas (1988; 2013) outline that the Concourse should be representative of the full spectrum of opinions, viewpoints, idea and reflections on a given subject, it should include all communication about a specific topic (Brown 1993) and can include everything from empirical literature, ordinary conversation, observations, commentary and discourse about everyday life around the field of study (Brown 1993; Watts & Stenner, 2005). Coogan and Herrington (2011) suggest that the Q-Set should be compiled from a wide variety of sources and should cover as many sub-issues within the theme or topic as possible so that the participants can truly express their views. This is so that these statements can be sorted in a way that permits the participants to either agree or disagree with the statements to derive subjective meaning about the subject. Watts and Stenner (2005) advocate the use of a systematic review of the relevant literature which can be disentangled into relevant themes, as well as using formal interviews, informal discussions, researcher observations and experience, and even the use of previously defined test or scale items.

The exploration of the Concourse can be undertaken through a variety of means but are generally regarded as being from primary sources (i.e. interviews, focus groups and discussions or conversations with other) or secondary sources (i.e. research literature, journal articles and newspapers). Coogan and Herrington (2011) recommend that if interviews or focus groups are used within the Concourse, these should be audio-tape recorded and transcribed verbatim to then allow the researcher to systematically go through the data to identify possible statements until all possibilities have been exhausted. Of note, it is also suggested that some of the individuals who will complete the Q Sort can also be used as the interviewees (Coogan & Herrington, 2011).

The responsibility essentially lies with the researcher to draw a representative sample of statements from the available sources explored within the Concourse (Ven Exel & De Graaf, 2005) and these must collectively cover all the elements of the field of study, i.e. should be representative of the full spectrum of opinions on a given subject (McKeown & Thomas, 1988). Similarly, Watts and Stenner (2012) outline that each statement derived from the Concourse must make its own individual contribution to the Q-set and that the statements when defined "sit neatly side by side without creating unsightly gaps or redundant overlaps" (p. 58).

Once all possible statements have been generated, they need to be sorted into categories to attempt to make sure that all aspects of the topic of interest to the researchers and participants have been covered (Coogan & Herrington, 2011), i.e. the Concourse process has reached saturation (Dey, 1993). This process can be made more robust by using an empirical strategy such as Thematic Analysis (Braun & Clarke, 2006) to define these categories.

3.4.2 Q-Set

The final Q-Set is a collection of statements that are different but make an assertion about the theme or field of study, i.e. the Concourse (Watts & Stenner, 2005). They are a heterogeneous set of items that the participants are required to sort (Brown-Walker, 2013) and aims to be a condensed or distilled representation of the Concourse topic. Because Q methodology is not a hypothesis testing method, what is very important in this methodology is that; (1) the research question is clearly and succinctly defined; (2) the condition of instruction for the participants to sort the statements is clear and derived from the research questions; and (3) that the Q-set is suitably representative of the field of topic to allow the participants to be able to sort meaningfully.

The Q-Set and the statements of which it is comprised form the units of analysis in the methodology (Paige & Morin, 2016) and there is usually a system or methodology that is employed in extricating or mining the statements from the Concourse. The process of extracting the statements from the Concourse is regarded as more of an 'art' than a scientific approach (Ven Exel & De Graaf, 2005) and can be undertaken by using a less formal and more subjective approach to group the statements into broad themes, but can employ a formalised empirical approach, for example using Discourse Analysis (e.g. Jorgensen & Phillips, 2002) or Thematic Analysis (Braun & Clarke, 2006). Whichever method is used, the essential process is that of ensuring that all possible notions, concepts, themes and aspects of the research topic are included without any overlap in the statements.

A Q-Set therefore needs to be a balance of reflecting the concepts and themes in the Concourse and practical and pragmatic ability to sort the statements in a meaningful and considered way that is not overly cumbersome or time consuming. This is because it is only when the participants are

sorting the statements that the statements develop their meaning (Watts & Stenner 2005) and the notion of operant subjectivity comes to life.

In unearthing the statements from the Concourse, the researcher usually creates many more statements than are practical or pragmatic to sort. As such, these need to be reduced or condensed in order to be practically meaningful to the participants to sort and broadly representative of the subject topic and field of study. A reduction in the statements can be undertaken by reviewing and re-reviewing the statements and by categorising them into representative themes reflecting the Concourse. These themes may be derived from the formal empirical approaches used, the qualitative strategies used or from subjective interpretation of the subject material. Paige and Morin (2016) identify that an inductive or a deductive approach can be used. An indictive approach is where the statements are selected without prescribing to an underlying theory or model, i.e. that they are derived from themes that are present in the Concourse and in the development of the statements. A deductive approach entails that statements are chosen relating to a theoretical paradigm or framework and these therefore reflect that framework. Similarly, statements have to be discarded, combined and amended to reduce the number to a useable Q-Set and in order that they are representative, clear, appropriate, simple and applicable (Cross, 2005). Likewise, it is suggested that the researcher looks to remove duplicates and statements that are ambiguous (Akhtar-Danesh et al., 2008); the statements need to be logically consistent with the conditions of instruction; and the terminology used within the statements need to be consistent, understandable and appropriate to the conditions of instruction (Watts & Stenner, 2012). Also, the statements need to be standardised and it is suggested that they contain only one proposition, that they do not contain double negatives and are salient and understandable (Webler et al., 2009).

It is important that when developing the final Q-Set to be used in a study there is a robust process of piloting and checking the statements in order that they are understandable, coherent and

inclusive. This can be achieved by evaluating the Q-Set with experts and piloting the Q-Set with participants (Paige & Morin, 2015).

With regard to the content validity of a Q-Set, the process of methodically ascertaining the Q-Set from the Concourse means that it is representative of the topic to be explored with the participants in the specific research study. Watts and Stenner (2012) suggest that the content validity of the Q-Set is usually established through expert advice sought during the exploration of the Concourse and when developing the statements from the Concourse. Content validity can also be increased by the use of more systematic and empirical means to extract the statements from the wider Concourse. However, Brown (1980) suggested that the notion of content validity for each statement in the Q set is generally a nonessential issue because the content validity of single statements is derived subjectively from their ranking in relation to the other statements by the participants. Meaning is given by the ranking and ordering of each statement in the vicinity to other statements, and the inherent meaning of each statement in the Q-Set is based on the holistic context of the entire sorting process, and not any a priori meaning given to statements beforehand by the researcher (Wigger & Mrtek, 1994).

3.4.2.1 Structure

A Q-Set is derived from the Concourse, and this can be done in either a *structured* or an *unstructured* manner. Structured sampling is often based on an existing theory or is derived inductively from an analysis of the Concourse as a whole (Webler et al., 2009). This means the Concourse can be broken down into themes or aspects of relevance that are organised around a theoretical framework. This then allows for the researcher to place some framework or boundaries on the range of phenomena of interest (Brown, 1980). In contrast, in an unstructured sample the

Q-Set can be a selected randomly from the Concourse (Barchak, 1979), where the statements selected are a representation of the Concourse as a whole but where sampling is not done evenly or robustly from the whole Concourse (Watts & Stenner, 2012). The underlying constructs that comprise the statements in the Q-Set are not considered in this process (Kerlinger, 1973). Brown (1980) suggests that either method allows different participants to interpret the same statements differently because the important information is the meaning the participants derive from the statements when they sort them (Brown, 1980).

3.4.2.2 Source

The statements in the Q-Set can also be developed through *naturalistic* or *quasi-naturalistic* process. The naturalistic method involves defining statements drawn from data such as transcripts, interviews or focus groups undertaken specifically and only for the purposes of development the Q-Set. A Quasi-naturalistic process however permits the use of secondary sources such as the researchers own experiences, the literature surrounding the topic of investigation and can include interviews from individuals that are not involved in the Q-Sorting process. There is a third means by which the Q-Set can be developed, i.e. using a ready-made Q-Set, which involves the use of previously standardised and validated measures or those developed from other sources not within the Concourse, i.e. psychometric questionnaires or survey questionnaires.

3.4.2.3 Number of Statements

The Q set represents all of the ideas necessary to answer the research questions (Barbosa et al., 2008) and the size of the Q set used will be determined by the subject matter (Watts and Stenner,

2012), although pragmatic considerations should also be made, for example the time it will take for participants to complete the sort (McKeown & Thomas, 1988). Effective Q studies have been completed with both very large and very small Q-Sets, and studies have shown that the number of factors resulting from the analyses do not change with the use of smaller Q sets (Watts & Stenner, 2012).

The Q-set is usually much smaller than the original Concourse as the development of the statements that make up the Q-Set are distilled from the wider Concourse. Recommendations for the number of statements are wide ranging (Dennis, 1992; Watts & Stenner, 2005), with Cross (2005) suggesting a range of between 10 and 100 statements, Webler et al. (2009) suggest between 20 and 60 statements, and where the typical number has been identified as between 40 and 80 statements (Curt, 1994; Stainton-Rogers, 1995; Watts & Stenner, 2005). The final Q-set should be representative, clear, appropriate, simple and applicable (Cross, 2005).

3.4.3 P-Set

The purpose of Q Methodology is to find patterns of subjective thought among people (Valenta & Wigger, 1997) around a given topic and theme under investigation. In order to do this the participant group, or P-Set becomes an important factor. The P-Set is the selected group of participants undertaking the Q-Sorts within the parameters of the research and their sorting of the statements produce the data that is then factor analysed and interpreted. The P-Set therefore is a selection of participants that offer a representative group around the field of investigation, they need to be people theoretically relevant to the problem of the study and whose perspectives matter in relation to the subject being investigated (Brown-Walker, 2013).

The selection of the P-Set can be *theoretical* and *random*, with *extensive* or *intensive* considerations (McKeown & Thomas, 1988). It is neither common to use a random selection of participants nor to use opportunity sampling methods (Brown, 1980). A *theoretical* sample are participants that are chosen specifically for the purpose of the study with the premise that they will hold different/ similar viewpoints about the subject topic, for example a given cohort of people. A *random* sample is known as an opportunity sample and might comprise a survey type research design. This is inconsistent with the empirical foundations of Q Methodology because the process, unlike R methodology is not to generalise to wider populations.

An *extensive* sample is one where the group of participants in the research study sort the Q-Set under the same conditions of instruction. This can be undertaken at one time point or multiple repeat sorts under the same instruction over a given time period. An *intensive* sample however is one where the participants are requested to sort the same Q-Set under multiple different conditions of instruction. This can also be undertaken at one time point or over a given time period, for example in a single case study design.

Sample size is much less of a concern in Q Methodology than in R methods, and large participant numbers are not required for meaningful Q studies (Watts & Stenner, 20005) because subtle nuances and complexities of the subjective experiences contained with the data can often be lost. Q Methodology is the exploration of subjectivity and operant meaning and is not aimed at generalising to a wider population (Willig & Stainton-Rogers, 2008).

Stephenson (1953) suggested that a P-Set in a Q study could be as small as one participant, whereas other leading Q researchers have provided varying P-Set sample numbers, with recommendations including a 1:1 ratio of participants to statements (Watts & Stenner, 2005); a 1:2 correspondence of participants to statements (Brown, 1998); and participant to statement ratio of between 1:2 and

1:3 (Webler et al., 2009). However, it has also been noted that the numbers are relatively arbitrary (Watts & Stenner, 2005) and that small numbers of participants can be used to generate very significant and meaningful conclusions (Watts & Stenner, 2012).

What is pertinent in Q Methodology is that the P-Set is derived from a sample that is representative of the field of study and includes those that are meaningfully able to provide subjective views on the said subject. As such a 'purposive sample' (e.g. Patton, 2002) can also be used within Q Methodology in which a P-Set are the participants that are representative of the environment or context being studied, e.g. within Mediation Training (Brown-Walker, 2013) and Psychotherapy Training (Ablon & Jones, 1998).

3.4.4 Administering the Q-Sorts

A Q-Sort is the process whereby the participants rank order the statements (Q-Set) relative to how much they agree or disagree with them, or how they view the statements as being important or not important. This process is undertaken through the specific conditions of instruction, which in turn is informed by the research question (Watts & Stenner, 2005). Brown (1993) describes the condition of instruction as a rule according to which the participants are asked to consider the statements and is the "technical means whereby data is obtained for factoring" (p. 17). The clarity and conciseness of instructions that are given to participants to conduct the Q-Sort is critical to the validity of the study (Wigger & Mrtek, 1994). The merits of Q Methodology is that it enquires about subjective individual interpretations of meaning of a given set of stimulus statements to those individuals. The subjectivity of the statements is acknowledged by asking participants to sort the statements according to personal significance based on their experience.

Administering a Q-Sort involves three activities for participants. Firstly, having read through the statements carefully, the participants are asked to sort the statements into three categories, those that they find most important, neutral and least important. This is to begin to orientate the participant to those statements that they find most or least important and helps to structure the finer grained value judgments necessary in the full sorting of the statements (Watts & Stenner, 2012). Secondly, the participants are asked to rank order the statements along the defined and structured grid on the Card Sort Table. Participants start with those statements they found most important, then move to those they find least important, and finally sort the statements they found to be more neutral.

Thirdly, the participants provide qualitative post-sorting information through undertaking a researcher-led interview following the Q-Sort. This is in order to have the opportunity to explore their thinking behind how they sorted the statements and to provide explanation of the meaning they made of the salient statements. A post-sort interview is suggested to be very important (Brown, 1980) and increases the richness and quality of the data (Gallaher & Porock, 2010).

3.4.4.1 Numbering and Naming

The naming and numbering of the dimensions on which the statements must be sorted needs to indicate extremes of positive and negatives on both ends, with the middle of the distribution reflecting the items of lower or neutral importance. The most validated distribution used is of a near-normal and symmetrical distribution with a positive value at one end, a negative vale at the other and with zero in the middle. Brown (1980) provides general guidelines for the range of distributions related to the number of statements in the Q-Set, suggesting a nine-point (-4 to +4)

distribution for 40 items or less, an 11-point (-5 to +5 distribution for 40-60 items), and a 13-point (-6 to +6) distribution for sets of 60+ items.

When undertaking a Q-Sort, participants are asked to sort the statements according to how much they feel the statement represents their view on the issue presented in the condition of instruction. It usually ranges from 'most agree' to 'most disagree' (Brown, 1993), but can also be under other labels such as 'most important' to 'least important', 'most interesting' to 'least interesting' or 'most relevant' to 'least relevant'.

3.4.4.2 Forced Vs Free

The distribution by which the participants sort and rank the Q-Set can either be a *forced* or *free* distribution. A forced distribution is where there is a fixed number of placements at each of the ranking points (i.e. 4x statements ranked at +3 and 3x statements at +4 etc). A free distribution however permits the participants to rank any number of statements to any of the ranking positions. Watts and Stenner (2012) identify and advocate for the use of a forced choice distribution as being the standard for Q-Sorts as this encourages participants to reflect on the statements in a more focused fashion and provokes deeper engagement with the statements (Brown, 1980). Importantly, however Brown (1980) advised that there is no right or wrong way to complete the Q-sort and has found that there are no meaningful effects of the distribution in the factors that arise from the sorting and the factor analysis, suggesting that the distribution in the way the statements are sorted is arbitrary.

3.4.4.3 Range and Slope

In deciding how participants sort the actual cards on the Card Sort Table, the key elements of developing this include (1) the kurtosis of the distribution, (2) the numbering and naming of the distribution and (3) the range and slope of the distribution. The kurtosis of the distribution depends upon the process of the distribution, the conditions of instruction and the research questions (Brown, 1980). Watts and Stenner (2012) suggest that a more flattened distribution is most useful in studies with more straightforward topics, but that more complex topics would benefit from steeper distributions to allow for more choice to be offered to participants in the neutral or lower importance areas (middle) of the distribution. This also permits an increased indeterminacy in sorting the statements in the middle of the distribution to promote thought and reflection on the statements being sorted. This is more helpful when the interest or knowledge of the respondents is expected to be low (Van Exel & de Graaf, 2005).

3.5 Q Factor Analysis

The quantitative element of Q Methodology involves the factor analysis of respective Q-Sorts for each participant and is regarded as being the scientific basis of the methodology (Van Exel & de Graaf, 2005). In Q Methodology a By-person Factor (or inverted) Analysis is undertaken, whereby the correlation is between persons instead of items used as in conventional factor analysis. This is regarded as Q-Factor Analysis. The final subjective card sort configuration actively produced by each participant is correlated with every other configuration in the data set (Watts & Stenner, 2005). The relationships between the Q-Sorts for each participant are calculated to identify common viewpoints, where each viewpoint produced represents a group of participants who have

given a similar subjective perspective in relation to the issue, and therefore can be seen to share a social viewpoint (Akhtar-Danesh et al., 2008).

There are now a number of software packages available to analyse Q-Sort data as there are no structures in SPSS for analysing the factor arrays used in Q Methodology (Watts & Stenner, 2012). The most widely used is PQMethod (Schmolk, 2014) and Ken-Q (Banasick, 2016), and both of these packages can be downloaded and used free of charge. Both of these software packages allow data to be inputted either manually as data is collected or imported from another software package such as Excel. Both use Centroid or Principle Component methods of Factor Analysis as well as permitting the resultant factors to be rotated analytically or judgementally as in conventional factor analysis. Similarly, PQMethod produces tabular representations of the factor loadings, statement factor scores, and the distinguishing and consensus statements across factors (Schmolck, 2014), whereas KEN-Q also produces visual representations of factor rotations and factor loadings.

The analysis of data using Q-Factor Analysis follows five stepwise analytic processes, namely (1) a correlation analysis of all the Q-Sorts giving a correlation matrix; (2) a factor analysis of the correlation matrix; (3) a process of factor extraction is then undertaken; (4) factors are then subjected to a rotation analysis; and (5) then this quantitative data is analyzed alongside qualitative information to gain a holistic or all-inclusive interpretation of the Q process.

3.5.1 Correlation

As each individual Q-Sort is undertaken, the data (i.e. the position of the Q-Sort Cards on the Card Sort table) is entered into an analysis program (e.g. Ken-Q Analysis). A correlation matrix is produced, whereby the participants form the columns and the statements form the rows, thus

permitting the inverted or by-person factor analysis at the next stage of the analysis (Brown-Walker, 2013). In essence, the correlation matrix demonstrates the relationship between each individual Q-sort with every other Q-sort (watts & Stenner, 2005) to identify the participants that sorted the statements into a similar ranked order (McKeown & Thomas, 1988). The correlation matrix essentially reflects the inherent agreement and disagreement between the individual participants (Van Exel & de Graaf, 2005). This process is regarded to be necessary to be able to reveal the underlying factor structure within the data (Brown, 1991).

3.5.2 Factor Analysis

The data is then reduced by use of factor analysis to identify the number of natural groupings of Q-Sorts by similarity to one another (Brown, 1980), i.e. the patterns of similarity in the Q-sort configurations or Q-Sorts that carry a family resemblance (Brown, 1993). A factor is a combination of participants whose sorting of the statements is statistically alike and factors themselves are a construct by which the correlations between participants is defined. Child (1970) defines this as the 'orderly simplification' of interrelated information to make sense of the complex relationships in the data. Brown (1993) explains that "the number of factors tells us how many different families there are in the data" (p. 111). Participants with similar rankings of statements will load significantly on the same factor, revealing a pattern of statements that express similar subjective views (Coogan & Herington, 2011). If participants produce similar Q-Sorts, it can be deduced that they hold a similar subjective viewpoint about the topic because they have interpreted and placed their statements in similar positions on the Card Sort Table.

Within a Factor Analysis there are a number of different extraction methods, however within Q Methodology there are two primary means by which factors are determined prior to any rotation

of the factors (Dziopa & Ahern, 2011; Watts & Stenner, 2005;). These are Principle Components Analysis (PCA) and Centroid Analysis (CA). The CA method has historically been the default choice in Q Methodology (Watts & Stenner, 2005) as the focus of this method is upon the commonality of the data among the Q-Sorts leading to a richer understanding of the context, instead of relating to the specificity of individual sorts as in PCA. CA is also suggested to allow the researcher a greater room for exploration of the meaning of the data (Brown-Walker, 2013) as it is a more exploratory method of factor analysis and is more frequently used when statistical precision is less important than understanding the operant subjective perspectives of the participants in the analysis. As a result of this, decisions about factors are made from an appropriate and considered theoretical position (Watts & Stenner, 2005).

PCA explains the variance-covariance structure of a set of variables. It achieves this through analysing the combinations of these variables through transforming potentially correlated variables into a smaller number of actually uncorrelated variables, called principal components. These principal components account for as much of the variability in the data as possible. PCM can be used to derive a relatively small number of factors from large amounts of data, and ostensibly allows for a reduction in the data so that this can be meaningfully interpreted and understood. Data reduction seeks to reduce the amount of data without the loss of a significant amount of information (Newman & Ramlo, 2010) and is regarded as being important because it may increase the ability to interpret the data in a more effective manner (Thomas & McKeown, 1988). PCM gives a statistically oriented best-fit solution to the data being analysed, but unhelpfully does not wholly incorporate the context in which the data was developed (Brown-Walker, 2013). However, little differences have been found in using either PCA or CA (Watts & Stenner, 2005), although it is noted that, unlike PCA which offers a mathematical solution, CA does not offer one best solution (Brown, 1980). This therefore means that the decision about how many factors to extract is more indeterminate, which on the one hand is less statistically driven, but in turn allows the researcher

to make theoretical decisions about the number of factors to extract (Ramlo, 2016) as opposed to using solely mathematical decisions.

To note, PCA and CA are both available extraction methods in many popular statistical packages designed for Q Methodology, as it is generally regarded that PCA focuses on both commonality and specificity to reach a mathematical solution (et al., 2009). Similarly, CA is considered by some as being obsolete and outdated (Choulakian, 2003) given the ease of computation and statistical rigour of PCA.

3.5.3 Factor Extraction

The number of factors extracted from the data is a decision made by the researcher. This is based on an evaluation of Eigenvalues, distinguishing statements and number of participants loading on all factors (Coogan & Herington, 2011). The objective of extracting factors is to incorporate the most amount of data (i.e. participant Q-Sorts) into the smallest number of factors, whilst also accounting for confounded sorts (i.e. Q sorts that load with statistical significance on more than two factors or do not load statistically on any factor (Watts & Stenner, 2010). Confounding Q-Sorts are often excluded from further data analysis (Akhtar-Danesh et al., 2008). Participants will only significantly load on a factor if their pattern of statements is (as a whole) different from the other patterns of statements shown by the participants who loaded on the other factors (Coogan & Herington, 2011).

The dilemma of how many factors to extract in a Q Methodology study is persistent amongst experts in the field. Watts and Stenner (2012) suggest the number of factors for extraction is dependent upon the study size, for example a study with less than 12 Q sorts could start with two factors, progressing to potentially seven factors for a study with greater than 36 Q sorts. Brown

(1980) however suggests starting with extracting seven factors, and then this can be reduced or increased as is required through the analysis. Ordinarily, between two and five factors tend to emerge (Watts & Stenner, 2012).

There are statistically driven means to extract factors, namely using (a) the Kaiser-Guttman criterion (Guttman, 1954; Kaiser, 1960, 1970 cited in Watts and Stenner, 2005); (b) the number of significant loadings on a factor and (c) using Humphrey's Rule (Brown, 1980; Watts & Stenner, 2012). According to the Kaiser-Guttman Criterion, only factors with an Eigenvalue >1 should be retained as factors. This is derived from the logic that when calculating an Eigenvalue, each variable (participant) is assigned an Eigenvalue of 1, therefore if a factor has an Eigenvalue of <1 it means that the factor explains less of the results than would be obtained from one participant. Factor analysis is used to reduce and simplify the data, so if the analysis included factors with Eigenvalues of <1, there would not be a data reduction process in analysing the data. However, if certain factors do not reach an Eigenvalue >1, these are not always automatically discarded as this process may create a ceiling or a flooring effect in the number of factors, i.e. whereby factors are overlooked or overly included to make sense of the variance (Brown, 1980). Similarly, the significance of the factor as a whole in explaining the variance in the data is also related to the coherence of this factor in relation to the other factors identified, as opposed to being solely about the Eigenvalue (Coogan & Herington, 2011). As an example, Brown (1971, cited in Dziopa & Ahern, 2011) outlines a study in decision making in psychiatric wards where three factors had Eigenvalues greater than one, but these excluded the team leader who was the primary decision maker in the team. The team leader alone loaded on a fourth factor and therefore a fourth factor was included in the analysis as it reflected the viewpoint of the primary decision maker.

In order to account for this potential effect, Watts and Stenner (2005) highlight that alongside the use of Eigenvalues, a significant factor loading can also be used to extract variables. Here, a factor

that has two or more significant loadings after the factor analysis can be considered as a factor for interpretation. This method means that if two or more Q-Sorts are identified as being significantly correlated with a factor, this then makes it meaningfully interpretable. Thirdly, Humphrey's Rule outlines that a factor is significant if "the cross product of its two highest loadings exceeds twice the standard error measurement" (Brown, 1980, p. 223). Using this formula can also identify factors that are meaningfully interpretable.

What is important is that the full range of interpretations and factor solutions are explored rather than being reliant on the statistical cut off using the Eigenvalue (Watts & Stenner, 2012) and before identifying any one statistically-based solution (Neuman & Ramlo, 2010). Watts and Stenner (2012) also use the term common variance which is the "proportion of the meaning and variability in a Q-Sort that is held in common with or by the group of participants" (p .98). The greater the level of shared variance that is explained by the factors, the more effective the factor analysis has been in identifying what the Q-Sorts share in common. For example, Watts and Stenner (2012) state that a total study variance of greater than 35-40% should be considered robust. When extracting the factors, an amount of shared meaning between some of the participants will be identified and a factor created to represent that portion of shared meaning. The remaining shared meaning amongst the participants will be defined by a second factor extracted by the factor analysis when analysed. This then continues until there are no more factors to be extracted.

3.5.4 Factor Rotation

Brown (1991) described that "the original number of factors from the factor analysis provides the raw materials for probing the subjective relationships from vantage points that might interest us" in the analysis (p. 112). The purpose of analyzing the factors through rotation is to reach a final set

of factors through exploring different perspectives of seeing the factors. In any rotation the relationships between the Q-Sorts is not altered, only the lens by which they are viewed. There are two predominant rotation options, *statistical* and *theoretical* rotation. The choice depends on the theoretical principles of the research. A theoretical or judgmental rotation is driven by a theoretical framework, prior knowledge or preconceived ideas by the researcher and permits the probing of the data to explore interpretations to hypotheses or theory driven by the study (Van Exel & de Graaf, 2005). A theoretical or judgmental rotation looks for the confirmation of a theory or an idea (Van Exel & de Graaf, 2005), although not all studies will have a theory confirmation objective. Because of the notion of operant subjectivity and of abduction being inherent in Q Methodology, Brown (1980) advocates the use of a theoretical or judgmental rotation as it is consistent with the explanatory and exploratory underpinning of Q as a method. This method when used with smaller sample sizes can be more effective in identifying patterns which then make the theoretical or judgmental rotation an effective choice to investigate the underlying theory in the data.

Many researchers however regard the technique with suspicion as it may be subjective or unreliable (Brown & Robyn, 2004), "as questions are posed as to whether a factor solution derived in this way reflects the reality of the data, or reflect the researcher's own understanding of that data?" (Watts & Stenner, 2012, p. 123). The primary reason to use manual rotation of the factors is to explore a factor solution that includes a participant or a group of participants in the minority whose viewpoint may be critical to the research questions (van Exel & de Graaf, 2005).

A *statistical* or Varimax Rotation is an easy to use computer generated technique that maximizes the similarities and differences between the factors orthogonally. It is thought of as an appropriate technique to use if you are seeking to understand the majority of the viewpoints from the participants as it automatically maximises the amount of study variance explained (Watts & Stenner, 2012). Varimax Rotation can be used when the researcher wishes to minimise the

potential influence of their subjective position on the data as it creates a simple solution based upon statistics rather than the researcher searching out for particular patterns. The Varimax Rotation method can follow both the use of PCA and CA in the factor analysis stage. Manual rotation can also be chosen after a PCA and CA methods. The Centroid Factor Analysis is generally followed by a theoretical or judgmental rotation but choosing a Varimax Rotation following a theoretical or judgmental rotation is also regarded to be able to produce meaningful and relevant results (Watts & Stenner, 2005).

3.5.5 Factor Computation

The final process in data analysis before describing and interpreting the factors is the calculation of factor scores, factor arrays and consensus/distinguishing statements (Van Exel & de Graaf, 2005). This is undertaken after all factor analyses and rotational analyses are completed. A factor score is the normalized weighted average statement score, or Z-score of respondents that define the factor (Van Exel & de Graaf, 2005). These Z-scores are amalgamated to create what is defined as a factor array, or an idealized Q-Sort for each factor that can be mapped on to the original Q-Sort distribution. The factor arrays, or 'model' Q-Sort represent how a hypothetical participant with a 100% loading on that factor would have ordered all the statements in the Q-Set (Van Exel & de Graaf, 2005; Watts & Stenner, 2012). All of the Q-sorts that load on one factor are used to create a factor array for that factor.

In order to derive further meaning to the factors identified, a number of statistically significant statements are identified that demarcate as either being statistically different or similar across the factors. A *distinguishing statement* is found on factors when the participants who loaded on that factor have placed a statement in a position, (e.g. 'most important') that is significantly different to

where all the participants who have loaded on the other factors have placed that particular statement (Coogan & Herington, 2011). Therefore, distinguishing statements help to understand the qualitative nature of that factor by identifying the differences in that factor to two or more other factors. Similarly, *consensus statements* are where participants who have loaded on a factor have placed a statement in a position in the distribution that is the same as a significant number of other participants in other factors. This therefore this tells you that there are areas of the Q-Set that the participants agree upon (Coogan & Herington, 2011). The number of distinguishing statements represent the number of factors, as there will be a set of distinguishing statements for each factor identified; whereas there is only one set of consensus statements across all factors identified (Brown-Walker, 2013).

These distinguishing and consensus statements, alongside the qualitative placement of the statements in the polar ends of the distribution (i.e. 'most important' and 'least important') and the qualitative information derived from the post card sort interviews help to develop the discourse and the narrative for interpreting each factor. This brings to life the inherent meaning of the factors contextualized within the research study. The data analysis of the Q-Sorts, including the consensus and distinguishing statements is then integrated and combined with the qualitative information gained from the post sort Interviews to gather a more universal understanding of the Q Sort experience and to understand the more idiographic meaning when participants are sorting the statements.

Chapter Four
Research Methodology

4. Methodology

4.1 Context to The Research

The aim of the current research project is to explore the experience of staff working within three National Probation Service approved premises as they progress through the development and implementation of a psychologically informed culture, i.e. an Enabling Environment. Enabling Environments are groups, organisations or places where positive relationships are there to promote well-being for all involved and can be found anywhere that people live, work or come together for a specific purpose. This includes hospital wards, supported accommodation, working environments, voluntary groups; and specifically, with regard to this study, in approved premises which are supported residential accommodation environments for individuals being released from prison who are regarded as high risk of further offending behaviour and who require support and professional supervision.

The Enabling Environment initiative is a therapeutic process that has been developed by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI, 2013) that leads to the establishment of a supportive, positive relational environment that encompasses all residential and treatment services. This process is something that all residential services (i.e. approved premises) within the Offender Personality Disorder Pathway are expected to achieve (Benefield et al., 2015). It is, therefore, important to understand the nature and culture of these developing environments and what aspects contribute to positive therapeutic spaces, especially given that these

environments are persistently dealing with individuals with complex needs, challenging behaviour and personality and mental health difficulties.

In practice, how staff perceive their experiences of being in an approved premise is largely unknown, and no research has yet explored the development of an Enabling Environment within approved premises, especially one that follows the process longitudinally. The aim is therefore to explore staff experiences and perceptions of the Enabling Environment over time as this initiative is implemented within three National Probation Service approved premises within the Thames Valley area.

This research project focussed on staff working within the approved premises and not the residents residing in these places because, at the time of the research study, the Enabling Environment initiative was being first implemented. The development and implementation of this initiative, as a change to the therapeutic culture of the approved premises was from a 'top-down' approach, i.e. it was being developed and led by staff, but with integration and collaboration with residents through their active involvement. Peplau (1989), for example suggested that because the milieu of therapeutic environment is considered a treatment modality, those involved in working within such environments have a role in the creation and maintenance of this milieu. The Enabling Environment process represents one of the strategies aimed at shifting away from the notions of supervision and monitoring to meaningfully engaging individuals to reduce the risk of further offending (Cherry & Cheston, 2006). As such, they are defined as specific environments where staff members have additional training to develop an increased psychological understanding of their work (Bainbridge, 2017) to "create an enhanced safe and supportive environment, which can facilitate the development of those who live there" (Turley et al., 2013, p. 2). Due to the paucity of research into such environments and that much of the evidence from the research literature tells us that meaningful therapeutic environments require collaboration between staff and residents (e.g.

Bender, 2005; Bennett & Shuker, 2010; Blais, 2004; Johansson & Eklund, 2004) this research is focussed on staff as a starting point to begin to build a more robust understanding of this field of study. Furthermore, there are empirical and methodological difficulties in involving residents residing in the approved premises in this research, for example the typical short length of stay and high turnover of residents meaning that exploring their perspectives and viewpoints whilst the Enabling Environment initiative was being developed would have potentially resulted in more limited findings.

4.2 Research Design

The research will explore with the participants what they think is important within their own environment to understand their individual subjective experiences of what they think forms the culture and therapeutic environment of that space. The study explores whether the participant's perspectives of this space change over time with more practical and social-environmental exposure to this therapeutic culture. This study will also endeavour to define the nature of an Enabling Environment as it exists within such approved premises and to understand the developing therapeutic culture that exists.

In order to achieve these overarching aims this research project involves two different Q Methodology studies, Study One and Study Two being in two parts (Part A and Part B). **Study One** uses a conventional Q Methodology design, where expert clinicians working within therapeutic environments completed the Q-Sort on one occasion. This study explores how these experts construct a shared understanding of an 'ideal' Enabling Environment as well as to develop a 'prototype' or 'ideal' Q-Sort which will be a function of the data analysis, in that it creates an ideal

Q-Sort to which other Q-Sorts can be compared (through correlational analyses) across the three timepoints in Study Two (Part B).

Study Two (Part A) uses Q Methodology in a repeated measures longitudinal design with pre-implementation, mid and (anticipated) post-Implementation data collection points with staff participants working within each of the three approved premises. This is to (1) explore the viewpoints of the staff in the approved premises prior to the Enabling Environment initiative beginning; and (2) to explore whether the participant's perspectives towards the Enabling Environment space changes over time. This is in order to understand the developing therapeutic culture that exists during this process. Essentially, this study asks the question; "do staff change their views of the Enabling Environment as they progress through the Enabling Environment process and do these views become more consistent with an Enabling Environment culture?"

The long-term experience of staff undertaking the implementation of the Enabling Environment initiative is the focus of the evaluation. Q Methodology, involving sorting pre-defined statements and a By-Person Factor Analysis was used to investigate the structure of the participants' perspectives before, during and at the end of the implementation of the Enabling Environment initiative. Because the variables did not involve specific traits to be studied across participants but rather the specific subjective experiences of the participants, both individual and collective, the aim is to explore what they think is important within their own environment, and to understand their individual subjective experiences of what they understand forms the culture and therapeutic environment of that space over time.

Study Two (Part B) is a comparative analysis of the viewpoints of the staff participants at each of the three timepoints resulting from Study Two (part A) with the expert participant viewpoints achieved in Study One. This study uses a Bivariate Correlation Analysis of the Z Scores derived for

each Factor yielded through the two studies. This comparative exploration of the relationships between the expert Factors and the staff Factors aims to investigate whether there is any difference in associations with what is defined as an ideal Enabling Environment the longer or the closer the staff are engaged in implementing the Enabling Environment initiative.

4.3 Data Collection Overview

Q methodology (Stephenson, 1953) was developed as a means to explore the subjectivity of people's experiences to attempt to explain, from the point of view of the participants, and to explore what the shared perspectives are around a theme in focus (Watts & Stenner, 2005; 2012). Q methodology was therefore chosen as a means to explore the subjectivity of experience, and to attempt to explore and explain complex socially constructed viewpoints from the point of view of the participants (Watts & Stenner, 2005), i.e. the staff working within the approved premises. In essence, a range of viewpoints were collected from a number of participants to understand what the shared perspectives are around the theme in focus (Watts & Stenner, 2005), i.e. the Enabling Environment initiative.

Brown (1980) identified five steps to implement the procedures of Q Methodology. The steps include:

1. Identifying a Concourse
2. Developing the Q-Set
3. Specifying the P-Set
4. Administering the Q-sort
5. Conducting data analysis.

4.4 Step One: Identifying the Concourse

4.4.1 Procedure

A Concourse is defined as the discourse, commentary, shared perspectives and themes surrounding a given topic or subject area and can be an ordinary conversation, commentary and discourse about everyday life and includes all communication about a specific topic (Brown 1993). The Concourse should be representative of the full spectrum of opinions on a given subject (McKeown & Thomas, 1988) and the subjective statements used in the Concourse can be pulled from varied sources (Brown 1993).

For this study the Concourse was derived from a number of sources; namely (1) a methodical review of the literature on therapeutic environments, relationships, milieu and cultures; (2) the author's own experiences, discussions and observations of therapeutic environments; and (3) focus groups with experts practicing within a variety of therapeutic environments analysed using a Thematic Analysis approach (Braun & Clarke, 2006).

The development of the Concourse produced the statements used within the Card Sort Assessment, i.e. the Q-Set, and thus involved two stages. The first stage involved sources (1) and (2). Themes, notions and concepts were drawn out by the author from their experience of working in such environments, as well as a review of the evidence base that contributes to the understanding of the nature and culture of these developing psychologically informed environments and to therapeutic spaces / cultures. The themes and concepts derived from the literature were developed into preliminary statements. A total of 114 potential statements were identified at this stage.

4.4.2 Focus Groups

The second stage involved using the data derived from a Thematic Analysis approach using the focus groups and an interview with experts in the field, i.e. (3). The focus groups used a semi-structured approach to facilitate discussions surrounding therapeutic environments. The interview schedule was developed iteratively. General themes of inquiry were considered, and questions formulated relating to the relevant literature. The questions were condensed until a final semi-structured interview schedule was developed (Appendix 1). The questions used within the focus groups were broad, open and exploratory to try to encourage discourse about the elements that comprise helpful and unhelpful therapeutic environments. Once the initial questions were developed, these were then piloted on an opportunity sample (N=3) in order to assess the clarity, transparency and focus of the questions. Expert participants were then identified to take part in the study and each one offered the opportunity to take part in a focus group. Each participant was given the relevant Information Sheet (Appendix 2) to read and given the ability to ask questions before any involvement in the research.

The total sample involved in focus groups and an interview was N=15. Participants were chosen because of their experience in both approved premises, Enabling Environments and in working within therapeutic environments. In summary, four focus groups and one interview was undertaken. The participants included; (1) five clinicians from an approved premise functioning as an Enabling Environment; (2) four qualified Psychologists; (3) two clinicians working within an approved premise that functions as a Psychologically Informed and Planned Environment (PIPE); and (4) three clinicians from the Royal College of Psychiatry involved in the development and national implementation of the Enabling Environment process. One stand-alone interview was conducted with a Clinical Psychologist who was unable to take part in the focus group arranged with the other Psychologists.

With regard to undertaking the focus groups, informed consent was obtained from each participant prior to involvement in the groups (Appendix 3). Each participant was invited to participate in a focus group. In order to identify and analyse the patterns emerging in the narrative of the data from the focus groups, each focus group was digitally audio recorded and transcribed following each focus group. This process further informed the themes of questions (around the prompts) within the subsequent focus groups and allowed for a more robust data collection process with the aim of being able to reach theoretical saturation (Dey, 1993) of the data (i.e. no further new themes arising within the focus groups or within the wider empirical literature).

Although undertaking a Thematic Analysis is not required to develop a Q-Set, using data derived from such an analytical method allows for a more robust empirical method to be used in the contribution to the development of the Concourse. Similarly, it allows for the systematic ordering and organising of themes arising from the data in a pragmatic and systematised manner. It is suggested that this process makes the identification of the statements more empirically valid. As such, the process of Thematic Analysis was undertaken, i.e. the data from the expert focus groups was analysed and the themes and concepts arising from the data were incorporated into the material used in the Concourse.

4.4.3 Integration of the Thematic Analysis into the Concourse

Braun & Clarke (2006) define six phases to analyzing data using Thematic Analysis. Data used in the Concourse was derived from Phases 1-5;

Phase 1: Familiarising yourself with your data

Phase 2: Generating initial codes

Phase 3: Searching for themes

Phase 4: Reviewing themes

Phase 5: Defining and naming themes

Phase 6: Producing the report

Once the focus groups were conducted and transcribed, the process of data analysis *proper* took place. The process started with reading and re-reading the transcripts to familiarise oneself with the data and engaging in a process of immersing in the data (Braun & Clarke, 2006). Through the process of transcribing, reading and re-reading the transcripts I was able to familiarise myself with the data and engaged in a process of 'immersing' myself in the data (Braun & Clarke, 2006). Through this one is looking for and noticing patterns of meaning and aspects of interest in the data through moving forward and back across the entire data (Braun & Clarke, 2006). The first phase involved generating a list of ideas, concepts and notions from the data working systematically through the transcripts giving equal attention to each aspects of the data. Notes were made in the margins of the transcripts and aspects of text were highlighted to identify emerging patterns. The means by which the data was approached was 'data driven' (Braun & Clarke, 2006), i.e. the codes and themes that arose were depended on the data, as opposed to approaching the data with a specific question in mind to orientate the codes and themes (i.e. theory driven). Examples of initial codes that were identified included; 'facilitating change', 'humanity', 'genuine', 'ownership', 'authority', 'belonging', 'respect', 'curiousness', 'person not problem' and 'acceptance' and 'change'.

Once the data had been reviewed several times and a list of codes identified and justified, the process of identifying themes in the data then took place. The process of identifying themes involved re-reading and re-reviewing the data repeatedly looking at broader themes as opposed to more singular and unified codes that reflect single aspects of the data. The development of the

themes involved evaluating the relationship between the codes and then the developing relationships between the broader themes being identified. These themes were then identified, and examples were drawn out from the data to exemplify the nature and content of the theme. Initial themes included; 'ownership', 'genuineness', 'boundaries', 'person not problem', and 'safety'.

Once these initial themes were identified and narratives were outlined to exemplify these themes from the data in the transcripts, these themes were then again re-reviewed by re-reading the transcripts to assess how the themes make sense of the data set as a whole. The process was to then ascertain if the themes were too inclusive or exclusive, and whether they reflected the data as a whole. Following this second review of the data and reflection on the themes, a total of six themes emerged that better represented the codes that were identified and the narratives in the data. These included; 'inclusion', 'collaboration', 'belonging', 'respect', 'safety' and 'boundaries'.

Through this second process of reviewing the themes, and in accordance with the meaning and representation of the data, the initial theme of 'ownership' was separated into the two subsequent themes of 'collaboration' and 'inclusion'. The themes termed 'belonging' and 'boundaries' remained as coherent, the theme named 'safety' was renamed 'sense of safety'. The theme respect was renamed as 'relatedness to others'.

The final stage of the data analysis at this stage involved defining and naming the themes. Once all of the initial themes and their identifying names were identified, these were then refined and defined (Braun & Clarke, 2006), i.e. identifying what the essence of the theme is about. This process was undertaken by identifying the narrative that each of the themes described and identifying how this was consistent with the research question and how this fitted with the rest of the data. Narratives from the data were then collated for each of the themes and they were then organised

and linked to accompany narratives from the data. The Thematic Analysis process identified six key themes arose from the process of undertaking the Concourse. These were;

1. Collaborative approaches
2. Being Inclusive / sense of belonging
3. Care of self / Care of others
4. Relatedness to others
5. Boundaries
6. Sense of safety

The most salient aspect of integrating the data drawn from the Thematic Analysis process into the Concourse was in the process of the identification of the narratives in the data that exemplified and defined these themes. The process of defining and naming a theme helped to categorise what the essence of the theme is about and identified pertinent concepts that needed to be considered in the Concourse, and as such the Q Set. Similarly, through the identification of narratives and discourse in the data that exemplified and defined the themes, further rich information was derived to inform the Concourse process, and to begin to structure what early statements might look like.

Through the process of generating themes from the initial codes in the data, the broader content of the discourse became apparent. A number of statements were derived directly from transcribed data or developed from the emergence of the codes and themes. This method also allowed for the organisation and description of the data set in rich detail (e.g. Braun & Clarke, 2006). Data extracts (i.e. narratives from the text) contributed to the content of the statements to use within the Q-Set.

As an example, statement (42) “We take a non-judgemental approach” was derived from the overarching theme ‘*Being Inclusive’* and was identified from the narrative of Participant 2 describing

the need for "valuing staff and residents and the environment, you know, those individual differences can be valued and tolerated". Statement (17), i.e. "There need to be clear expectations about how people behave" was derived from the overarching theme termed '*Boundaries'*, and was identified from the narrative of Participant 4, describing "in order to engage in meaningful therapeutic endeavour there has to be a therapeutic frame around the person, which includes around the group which includes around the relationship". Statement (23), i.e. "I ask myself 'how does this negative behaviour impact on others within this environment'?" was derived from the overarching theme '*Sense of Belonging'* and was identified from the narrative of Participant 2 describing "it is really showing people the part that they play and the value that they bring to it and why they are an essential component of that whole environment".

Following the Thematic Analysis process, the codes, themes and narratives from this process were added to the perspectives gained from the review of the literature surrounding therapeutic and psychologically informed environments and therapeutic relationships, and the author's own experiences and observations of working in such environments. The re-review of the research literature then took place with the codes and themes in mind, and further statements were developed. The statements identified from the whole Concourse process (i.e. from the literature, the author's experience and observations, discussions with others and the focus groups) were broadly arranged into the thematic groups that were identified through the Thematic Analysis process of the focus groups. This allowed for a more systematic review of the statements to reflect the major concepts that existed within the Concourse.

From the literature and the author's experience, 114 statements were initially generated. The Thematic Analysis yielded a further 63 statements and then a re-review of all the available information within the Concourse yielded a further 32 statements. A total of 209 statements were

then refined through the development of the Q-Set to reach the final 50 statements. This is described in more detail in Section 4.5 below.

4.5 Step 2: Developing the Q-Set

A Q-Set is the actual set of statements that represent as fully as possible the concepts and themes within the Concourse and that reflect the research question being investigated. They are the statements that the participants will think about and sort during the Q-Sort Assessment, and from the data inherent within the factors that are analysed within the study.

There is no set algorithm defining how many Q statements are required to undertaking an effective Q-Sort, however they need to be representative of the Concourse and contain all of the ideas necessary to answer the research questions (Barbosa et al., 2008). Watts and Stenner (2012) suggest that the final Q set will be determined by the subject matter, there should be consideration to pragmatism (McKeown & Thomas, 1988) and it should be representative, clear, appropriate, simple and applicable (Cross, 2005).

Initially, 209 statements were generated from the review of the literature, from the author's own experience and observations and the narratives and topics contained within the focus groups. These statements were arranged into the six key themes identified through the Thematic Analysis. These 209 statements were reduced to 50 statements through a process of removing duplication, ambiguity and unclear statements.

Essentially, the initial statements identified were reduced and condensed through a subjective but methodical process using three broad strategies of excluding, refining and consolidating. For

example, initial statements that were excluded included 'I think EE is a worthwhile process', 'I am hopeful about Enabling Environments' and 'Enabling Environments are helpful'. These were excluded in the process because they were loaded with focus on Enabling Environments rather than on therapeutic culture / milieu and would potentially have organised participant thinking towards collating Enabling Environments items together in the sorting. Similarly, the statements 'I am flexible to meet resident needs', 'I feel appreciated' and 'I am supported emotionally in my role' were excluded as they were too general in nature, context dependent and subjective in nature, and not regarded as integral to the nature of a therapeutic culture.

Examples of initial statements that were consolidated are outlined in Table 2 below. Those that were refined included;

Statement 45: 'The boundaries between staff and resident relationships are clear' was clarified, made less ambiguous and made more succinct from the initial statement of 'there are clear boundaries with residents'.

Statement 15: 'There need to be clear expectations about how people behave' was made more explicit and concrete from the statement 'there are clear expectations on me'.

Statement 13: 'I try to be curious in why people behave in a certain way' was refined from the statement 'I take a curious approach to problems' in order to be more specific to understanding the underlying functions of behaviour rather than being more generally curious about others.

The final statements were chosen as they reflected a robust coverage of the key themes and ideas in the Concourse, and they reflected statements of opinion and/or meaning and not aspects of factual information. Attention was further paid to ensure that the statements only contained one

proposition and that they were standardised so that they began and ended in a similar manner and could easily be sorted following the condition of instruction (Watts & Stenner, 2012).

These 50 statements were initially piloted by sending them out in a 'list form' to volunteers (N = 7) to reflect and provide comment upon them. This was in order to check the language, the content and structure of the statements, to reduce semantic duplication (Watts & Stenner, 2005), to appraise their ease of readability and understanding, to ascertain if they were easily interpretable and to ensure validity of the items (Brown, 2004). Feedback was received from all seven volunteers that included typographical errors, some ambiguity in the meaning of the statements, the identification of a double negative in a statement and potential replication in two statements. These were addressed, and the statements were reviewed and amended.

Table 2. Examples of initial statements that were consolidated.

There are shared goals we work towards Residents have goals to work towards Agreeing on goals to work towards with residents always happens There is a clear agenda	**Statement 19: We have shared goals about the culture between staff and residents**
Public protection is an important role of an AP Security is important I can cope with the challenges of the AP	**Statement 44: I keep in mind 'can we manage this type of behaviour'**
The AP is a safe place Communication is open Communication is important My ideas are valued	**Statement 49: Feeling safe to share our thoughts and emotions**

Following this initial pilot, in order to further check for understanding and language under the conditions of the sorting instructions (that is to evaluate the ease by which the statements could be sorted), to further check the validity of the items (Brown, 1998) and to assess for further semantic duplication (Watts & Stenner, 2000) during the Q-Sort process, a second pilot of three Q-Sorts was undertaken with volunteers (N = 3). No further constructive feedback was given about the content and wording of the statements. However, feedback included that a number of the statements were "difficult to sort" as they provoked much reflection and consideration about what the statements meant to them in particular. It was also fed back that the majority of the statements seemed indicative of a meaningful Enabling Environment, and therefore it made for "difficult decision making in how to rank [order] them". This was an important observation, given that it is advisable to use items that are closely related in meaning when the overall goal of the research is to ascertain nuances of responses by the participants (McKeown & Thomas, 1988). The pilot Q-Sorting by these three volunteers resulted in the final Q-Set.

Once the Q-Set was finalised, the 50 statements were put through a random number generator to fully randomise the statements and their respective statement numbers to eradicate any biases or clumping of statements of a similar notion or theme. The Q-Set took the form of a structured sample of statements (i.e. derived from a methodical and systematic review of the literature, extensive discourse and focus group data) using a quasi-naturalistic sample process (i.e. research participants are not those involved in the development of the Q-set).

Appendix 4 contains the final Q-Set following randomisation of the statements.

The 50 statements in the Q-Set were standardised in size and font and presented on 50 separate 150g/sqi card that were sized 64mm X 42mm. With the number of statements finalised, a Q-Sort Table was then developed to be used in the Q-Sort assessment. A forced choice distribution was

chosen with a near-normal and symmetrical distribution with a positive value at one end, a negative vale at the other and with zero in the middle. This kurtosis allows for more choice to be offered to participants in the neutral or lower importance areas (middle) of the distribution and is also suggested to permit an increased indeterminacy in sorting the statements in the middle of the distribution to promote thought and reflection on the statements being sorted. The chosen range was between +5 and -5 as a result of the 50 statements in the Q-Set (Brown, 1980). The extremes of 'Most Important' and 'Least Important' were chosen as this best reflected the conditions of instruction for the Q-Sort and the wording of the statements in the Q-Set.

The same Card Sort Table was used for all research participants (Appendix 5). The Q-Sort Table was A1 sized, contained 50 separate rectangles (sized 64mm X 42mm) to assist in the placement of the cards and was laminated. The conditions of instruction were placed on the card in the bottom right hand corner to assist in the process.

4.6 Step 3: Specifying the P-Set (Participants)

The P-Set is the participant group undertaking the Q-Sort assessments, i.e. the research participants, and these are the variables being analysed. The P-Set is best understood as the group of individuals theoretically and practically relevant to the objectives of the study and the research questions involved.

This study explores the experiences of staff working within approved premises, it represents a context-based study and the sampling of the participants was both strategic and purposeful in order to gain a representation of the staff experiences in their environment. The participants were purposefully chosen as they were theoretically relevant to the problem of the study, and not based

on random selection (Brown, 1980). As such, all staff that met the inclusion criteria at each of approved premises were invited to be participants, i.e. a representative sample.

In this research the P-Set was derived from two separate participant samples. The P-Set in **Study One** (i.e. Expert Panel participants) consisted of a group of experts practising in the field with academic and clinical experience and training or working within therapeutic environments, milieu and cultures (N=21). This sample size falls within the desirable ratio of participant numbers offered by Webler et al. (2009).

The P-Set in **Study Two (Part A)** consisted of clinical staff employed within each of the three approved premises volunteering to take part in the study. The aim of this study is to explore the staff perceptions of the approved premise as an emerging Enabling Environment as it changes over time, i.e. as the initiative is implemented. The staff cohort at three National Probation Service approved premises (GR, MK & ML) were invited to participate in the research. The full identifying details of the approved premises have been withheld to maintain anonymity. These acronyms will be used in the research going forward to identify each approved premise. The three approved premises involved in this research were chosen because of their geographical position, i.e. they were located in the same National Probation Service commissioning region; they provided a pragmatic ease of access; and at the time of beginning the data collection they had not yet begun the process of implementing the Enabling Environment initiative.

The participants in **Study Two (Part B)** consisted of those already included in Studies One and Two (Part A). No further research participants were recruited for Study Two (Part B) as it involved a secondary analysis of the results from both Study One and Study Two (Part A).

4.6.1 Approved Premise Sites

The three approved premises were chosen because of the reasons defined above, and because they fell within the remit of the South West and South Central National Probation Service commissioning region. They were also sites where the researcher had neither formal nor informal clinical contact. This was in order to maintain empirical objectivity and independence from the data collection process. Broadly, the three approved premises operate in a similar fashion and have nationally defined objectives, structures, staffing resources, processes and policies. There are however site-specific policies and procedures that could not be accounted for in the research. For example, two of the sites (ML and ML) are located within residential housing areas of major cities, whereas one (GR) is located in a residential housing area of a smaller town. The other difference between the sites is that two of the sites (MK and ML) offer their bed spaces to general, violent and sexual offenders, whereas the other (GR) predominantly offers bed spaces for those having committed sexual offences. This is not exclusive as they do offer beds to individuals with other offence types, but this is less common.

4.7 Step 4: Administering the Q-Sorts

4.7.1 Study One

4.7.1.1 Design

Study One follows a conventional Q-Sort assessment, where expert clinicians working within therapeutic environments completed the Q-Sort process on one occasion. Study One explores how these experts construct a shared understanding of an 'ideal' Enabling Environment. This ideal perspective as defined by the experts in the field is thus regarded as a 'prototypical' or ideal Q-Sort.

The use of this prototype will later serve a function in Study Two (Part B) where it will be compared to the viewpoints of the staff participants across time.

4.7.1.2 Participants

The participants consisted of a group of experts practising in the field with academic and clinical experience and training of working within therapeutic environments, milieu and cultures (N=21). The inclusion criteria included a minimum of six months academic and/or practical experience working within therapeutic environments. There were no exclusion criteria. The sample consisted of six Psychologists; one Psychotherapist; three Psychiatrists; three Managers of psychologically informed environments; six experienced Offender Supervisors working within psychologically informed environments; one experienced Residential Assistant working within a psychologically informed environment; and one Senior Operational Manager responsible for the national implementation of the Enabling Environments initiative.

With regard to the demographic data, 57% (N=12) were female and 43% (N=9) were male. The mean age of participants from the data provided was 46.3 years old (range 28 – 61) and the average length of time working within a therapeutic environment was 71.5 months (range 6 – 120). Five participants did not disclose their age.

4.7.1.3 Procedure

Data was predominantly collected between September 2017 and January 2018, with three participants being recruited later and took part in February 2019. Informed consent was obtained

for each participant at each stage of the research process. Participants were provided with information sheets and instructions on how to complete the Q-Sorts. The participants read the written instructions prior to completing the Q-Sort. Administering a Q-Sort involved three activities for participants. Firstly, the participants sorted the statements into three categories, those that they find most important, neutral and least important to begin to orientate them to the statements and help to structure the finer grained value judgements necessary in the full sorting of the statements (Watts & Stenner, 2012).

Secondly, the participant's rank ordered the statements along a defined and structured grid on the Card Sort Table. Participants start with those statements they found most important, then move to those they find least important, and finally sort the statements they find to be more neutral. Thirdly, the participants provided post-sorting information through undertaking an interviewer-led Post Card Sort Interview (Appendix 6) in order to have the opportunity to explore their thinking behind how they sorted the statements qualitatively and to provide explanation of the meaning they made of the salient statements. The post-sort interview is suggested to be very important (Brown, 1980) and increases the richness and quality of the data (Gallaher & Porock, 2010). Essentially, the Post Card Sort Interview asks the participants (1) to describe why they ranked the particular statements at both +4 and +5 and -4 and -5; (2) what specific statements they had difficulty sorting and why; and (3) to describe any thoughts they had about Enabling Environments whilst completing the Card Sort.

The Q-Sort followed the procedure of being an intensive person-sample (i.e. a number of participants sort cards under identical instructions), forced choice (i.e. participants required to place a specific number of cards on a specific number of piles, usually following a quasi-normal distribution) and quasi-naturalistic Q-sort technique. Participants were asked to sort and rank the

statements given into a quasi-normal distribution along a dimension of “Most Important” to “Least Important” (i.e. ranked values being between +5 to -5).

The participants in Study one completed one Q-Sort using the following condition of instruction; “How important do you think each statement reflects an ideal Enabling Environment”. The physical Q-Sort assessment took place at the participants’ respective places of work. The researcher was present throughout the time that the participants sorted the cards but was there only to observe. Once the participant had sorted all of the statements and was happy with their placement, these were then transcribed on to a copy of the Card Sort Table.

4.7.1.4 Data Collection Materials

1. Card Sort Table
2. 50 printed cards containing the Q-Set statements
3. Participant Consent Form & Instructions
1. Participant Information Sheet, Consent Form & Instructions
4. A table
5. Post Card Sort Interview Questionnaire
6. Pen

4.7.1.5 Data Analysis

The Q-Sorts were analysed using the prescribed Q Factor Analysis using an electronic statistical software package termed KEN-Q Analysis (Banasick, 2018; 2019). It was chosen because of it being

freely available from https://shawnbanasick.github.io/ken-q-analysis/, its compatibility with multiple computer platforms (i.e. PC and MAC) and a preferable user interface. KEN-Q Analysis is also well established as a methodology for Q Analysis within published literature (e.g. Walker et al., 2018; Nazariadli et al., 2019).

KEN-Q Analysis performs the By-person Factor Analysis, or the 'inverted factor analysis' where the correlations between persons is factored as opposed to the correlations between variables (Brown, 1980). Each factor that is identified represents a group of participants who have given a similar account in relation to the issue and therefore can be seen to share a social viewpoint (Akhtar-Danesh et al., 2008). The Q-Factor Analysis was used to ascertain factor scores and factor arrays to ascertain the contribution of each of the statements to each of the Factors and to ascertain core similarities and differences in the rankings of the statements. This generated the prototype Q-sort.

4.7.2 Study Two (Part A)

4.7.2.1 Design

The use of Q Methodology in **Study Two (Part A)** follows a repeated measures design with pre-implementation (baseline), mid (approximately six months) and post- implementation data collection points (approximately 12-18 months) with staff working within each of the three approved premises (MK, GR and ML). The implementation of the Enabling Environment initiative was the intervention being evaluated and this was undertaken through the exploration of perspectives towards this Enabling Environment initiative across these repeated data collection points. Each participant completed an identical Q-Sort on three separate timepoints, i.e. baseline (Time 1), at approximately 6 months (Time 2) and at approximately 12-18 months (Time 3).

This study has two objectives. Firstly, to explore the meaning and significance of how the participants make sense of the approved premise environment before the Enabling Environment initiative commences; and secondly, to explore the experience of staff working in the approved premises as they are engaged in the process of becoming an Enabling Environment over the time period. The aim is to understand what the participant's found to be important within their own environment and to understand the collective subjective experiences of what forms the culture and therapeutic milieu of that environment across time. This study asks the question; "do staff change their views of the Enabling Environment as they progress through the Enabling Environment process?".

4.7.2.2 Participants

Data was collected across three separate time points between September 2017 and February 2019. The inclusion criteria were that the participants at each of the three approved premises were employed either full time or part time in the approved premises at the times of the data collection. Table 3 below details the participants who were involved in this Study across each of the three timepoints at each of the three approved premises.

Table 3. Participant Details for Each Approved Premise at each Time Point.

Location	Research Number	Role	Time 1	Time 2	Time 3
MK	A1	OS	**Y**	Not in post	Not in post
	A2	RA	**Y**	**Y**	**Y**
	A3	OS	**Y**	Not in post	Not in post
	A4	RA	**Y**	**Y**	**Y**
	A5	Manager	**Y**	**Y**	**Y**
	A6	OS	Not in post	**Y**	**Y**
	A7	RA	Not in post	**Y**	**Y**
	A8	RA	Not in post	**Y**	**Y**
	A9	OS	Not in post	**Y**	**Y**
GR	B1	OS	**Y**	**Y**	**Y**
	B2	OS	**Y**	**Y**	**Y**
	B3	RA	**Y**	Not in post	Not in post
	B4	Manager	**Y**	**Y**	Not in post
	B5	OS	**Y**	**Y**	**Y**
	B6	OS	Not in post	**Y**	**Y**
	B7	RA	Not in post	**Y**	**Y**
	B8	Manager	Not in post	Not in post	**Y**
ML	C1	OS	**Y**	**Y**	**Y**
	C2	RA	**Y**	**Y**	**Y**
	C3	OS	**Y**	**Y**	**Y**
	C4	RA	**Y**	**Y**	**Y**
	C5	OS	Not in post	**Y**	**Y**
Total Participants			**14**	**18**	**18**

NB: OS – Offender Supervisor; RA – Residential Assistant

The only exclusion criteria related to a potential participant being 'agency' staff members who would be in post for a very short period of time, i.e. less than one month. Regarding participant involvement across time, as can be seen from the table above, a total of ten participants completed each of the three Q-Sorts at each of the three timepoints. A further seven completed both Time Two and Time Three and four participants had standalone involvement, i.e. they participated at either Time One or at Time Three. Of note, the sample size at time one falls marginally below the

desirable ratio of participant numbers offered by Webler et al. (2009), however the context-based and representative sample design of the study did not permit the sourcing of additional research participants.

With regard to demographic data, at MK approved premise 45% (N=4) were female and 55% (N=5) were male, the mean age from the data provided was 46.4 yrs (range 24-60 yrs) and the average length of time working at the approved premise was 56 months (range 1-116 months). Two participants did not disclose their age.

At GR approved premise 50% (N=4) were female and 50% (N=4) were male, the mean age was 45.7 yrs (range 25-59 yrs) and the average length of time working at the approved premise was 71.7 months (range 5-162 months).

At ML approved premise 60% (N=3) were female and 40% (N=2) were male; the mean age was 36.8 yrs (range 26-50 yrs) and the average length of time working at the approved premise was 58.8 months (range 1-180 months).

4.7.2.3 Procedure

Informed consent was gained for each participant at the initial stage that they were involved in the study, and they were asked again each time they participated if they wished to complete a further Consent Form. Participants were provided with Information Sheets and Participant Instructions on how to complete the Q-Sorts each time they took part. The participants read the written instructions prior to completing the Q-Sort. Administering the Q-Sort again involved three activities for the participants. Firstly, the participants sorted the statements into three categories, those that

they find most important, neutral and least important. Secondly, the participants rank ordered the statements along a defined and structured grid on the Card Sort Table. Participants start with those statements they find most important, then move to those they find least important, and finally sort the statements they find to be more neutral. Thirdly, the participants provided post-sorting information through undertaking an interviewer-led Post Card Sort Interview in order to have the opportunity to explore their thinking behind how they sorted the statements and to provide explanation of the meaning they made of the salient statements.

The Q-Sort again followed the procedure of being an intensive person-sample (i.e. a number of participants sort cards under identical instructions), forced choice (i.e. participants required to place a specific number of cards on a specific number of piles, usually following a quasi-normal distribution) and quasi-naturalistic Q-sort technique. Participants were asked to sort and rank the statements given into a quasi-normal distribution along a dimension of “most important” to “least important” (i.e. ranked values being between +5 to -5).

The participants in Study Two (Part A) completed one Q-Sort using the following condition of instruction; “How important are these statements to you”. The condition of instruction was identical for every participant, and each participant employed at the approved premises at all three timepoints completed a Q-Sort with an identical Q-Set. Table 4 below outlines the timepoints of the data collection at each of the three sites.

Table 4. Timepoints for Data Collection at Each Approved Premise.

	Time one	Time Two	Time Three
MK	Sept-Oct 2017	July-Oct 2018	Feb-Mar 2019
GR	Oct-17	May-Jun 2018	Dec-18
ML	Jan-Feb 2018	June-Jul 2018	Dec 18-Jan 19

After completion of the Q-Sort Assessment, each participant also completed the Post Card Sort Interview as per Study One. Alongside the Post Card Sort Questionnaire, each participant in Study Two (Part A) completed two further questionnaires, The EssenCES Questionnaire (Schlast, 2008) and The Working Alliance Inventory (WAI; Horvath, 1994; Horvath, & Greenberg, 1989). The EssenCES Questionnaire (Schalast, 2008) is a 17-item psychometric tool designed for assessing the traits of the social and therapeutic atmosphere within therapeutic environments. The questionnaire measures three component factors of therapeutic atmosphere / climate, i.e. Therapeutic Hold, Patient's Coherence and Support and Experienced Safety. The Working Alliance Inventory (WAI; Horvath, 1982; Horvath, & Greenberg, 1989) is 36-item self-report instrument for measuring the quality of alliance between treatment providers and recipients and is based on Bordin's (1980) tripartite (bonds, goals, and tasks) conceptualization of the alliance. The questionnaire measures three component factors of therapeutic alliance, namely Therapeutic Bond, Shared Therapeutic Goals and Therapeutic Tasks.

Of note, the data from these two psychometric questionnaires was not included in the analysis or interpretation of the data given the small sample sizes. As a result of the smaller than expected sample sizes achieved in this study, the required power was calculated post hoc using G*Power (Erdfelder et al., 1996). Although this is conventionally an a priori process, it was pertinent to do this given the large confidence intervals and large degrees of freedom found at the initial analysis

stage which meant that the data was not able to be robustly interpreted. As an example, for the comparisons of the data between Time One and Time Two, for a two tailed test with an estimated effect size (d = 0.8) and moderate probability of error (a = 0.05), the achieved power is less than adequate (1-B = 0.58). This means that there is only a 58% chance of detecting any actual significance at the $p < 0.05$ level. Furthermore, to ascertain the required sample size to achieve statistical power at the recommended 0.80 level of power (Cohen, 1988; 1992) with an effect size (d = 0.8) an N of 52 would be required. The largest sample size of 32 falls far below this, and as such the analyses with smaller sample sizes will have less power and little meaning can be derived therein.

Due to a number of methodological and researcher access difficulties, the timepoints at which the data was collected was not uniform and followed a staggered process. The initial baseline data collection period was at a similar time at MK and GR, i.e. within a parallel three-month period as planned. However, at ML due to access restrictions because of staffing resources, this baseline data collection did not take place until approximately three months later in early 2018. The second and third data collection timepoints at GR and ML followed the approximate six-month time period as planned. However, again due to access restrictions as a result of staffing resource difficulties the second phase of data collection at MK did not take place until approximately ten months after the baseline data was collected. These staffing resource struggles at ML continued on across the second phase of data collection, and ML also experienced significant difficulties in managing a number of complex aggressive residents that resulted in aggressive incidents. Furthermore, the third data collection point at MK was undertaken at approximately five months after the second time point (instead of the planned six months) to try and achieve a comparable end point in the data collection across the three sites for pragmatism in the analysis and completion of the research study.

Regarding the implementation and achievement of the Enabling Environment initiative through the period of the study, this was mixed across the three sites. Table 5 below summarises the progress made at each site.

Table 5. Progress in the Enabling Environment Initiative at Each Approved Premise.

	Time one (Baseline)	Time Two	Time Three
MK	No Awareness Training completed.	Active engagement with implementing the Enabling Environment process but marked staffing resource limitations. Had planned to submit Enabling Environment portfolio in May 2018 but deferred for three months.	Enabling Environment Assessment scheduled for February 2019 but rearranged to August 2019.
GR	Local Awareness Training completed.	Active engagement with implementing the Enabling Environment process.	Portfolio planned to be submitted in February 2019
ML	No Awareness Training completed.	No active engagement for 3 months (April-June 18) in implementing the Enabling Environment process due to staffing resource difficulties and aggressive incidents.	Enabling Environment Award achieved on 04/12/18.

At the baseline data collection, one of the approved premises (GR) had received only a brief 'awareness training' from their own institution, the other two had not yet received any such training. All three approved premises had not yet begun working towards implementing the Enabling Environment initiative. At the time of the second data collection period (i.e. Time 2) all three of the approved premises had begun working towards and actively implementing the Enabling Environment initiative. However, ML had suspended this active involvement for a period of approximately three months due to marked resource difficulties, staffing shortages and complex incidents relating to interpersonal violence within the resident group. Also, at MK data collection was delayed by 3-4 months again because of marked resource difficulties and staffing shortages.

At the time of the third data collection period (i.e. Time 3) one approved premise (ML) had completed and submitted the required Portfolio of Evidence and had achieved and received the Enabling Environment Award, and as such was recognised as an Enabling Environment. Similarly, GR were near completion of the required Portfolio of Evidence and had made formal plans to submit this in the February 2019 after the data collection was completed in December 2018. MK also had made plans to submit the Portfolio of Evidence in February 2019, however, were in a position whereby they were not as advanced in assimilating this Portfolio of Evidence because of similar resource, staffing and operational constraints.

4.7.2.4 Data Collection Materials

1. Card Sort Table
2. 50 printed cards containing the Q-Set statements
3. Participant Information Sheet, Consent Form & Instructions
4. A table
5. Pen
6. Post Card Sort Questionnaire
7. The EssenCES Questionnaire (Schalast, 2008)
8. The Working Alliance Inventory (WAI; Horvath, 1982; Horvath, & Greenberg, 1989)[1]

The two psychometric questionnaires, although they were not quantitatively analysed due to low participant numbers meaning any interpretation of potential statistical significance being unsound were used as additional information, alongside the post card sort interviews to add a further degree

[1] Note: the data from these two psychometric questionnaires was not used in the analysis or interpretation of the findings as described in Section 4.7.2.3 above.

of richness and substance to understanding the perspectives and viewpoints of the participants undertaking the Q-Sorts at each of the timepoints. Having a structured means to appraise the participant's perspectives on how they relate to, understand and foster the therapeutic relationships with the residents at the approved premise; as well as how they perceive the therapeutic nature of the approved premise environment will add to the qualitative interpretation of the factors and their meaning for this participant group.

4.7.2.5 Data Analysis

The Q-Sorts in this Study were again analysed using the electronic statistical software package termed KEN-Q Analysis (Banasick, 2018; 2019). Due to low participant numbers at each approved premise at each timepoint, the collective Q-Sorts from the three approved premises (MK, GR & ML) were combined and analysed collectively. The participants at each time point were subject to a Q Factor Analysis to obtain the collective viewpoints and perspectives of the participants as a whole at these timepoints.

4.7.3 Study Two (Part B)

4.7.3.1 Design

Study Two (Part B) is a mixed methods study involving both a correlational research design and a subjective qualitative narrative description of the collective viewpoints of the participants across time. The analysis is therefore in two parts. Firstly, the focus of the analysis is in understanding the relationships between the Expert Factors found at Study One and each of the Factors derived from the staff participants at Timepoints One, Two and Three. Secondly, to provide a holistic

interpretation of the data, the similarities and differences in the viewpoints expressed by the participants (derived from the Q Factor Analyses) were qualitatively described.

The aim of this Study is to explore whether the participant's perspectives of this their environment and culture change over time with more actual, practical and social-environmental exposure to the Enabling Environment culture. The objective is to explore whether staff shift in their views (moving from explicit awareness to implicit understanding) of the Enabling Environment as they progress through the Enabling Environment process. There is a logical supposition that the views of the Enabling Environment culture as defined by the participants will more aligned with the Enabling Environment culture as defined by the Experts the closer the environment is to being awarded the Enabling Environment status.

4.7.3.2 Participants

The participants in this Study are comprised of those who consented to and were involved in the research through Study One and Study Two (Part A). Participant numbers and demographics are defined above in Sections 3.5.2.2 and 3.6.2.2 respectively.

4.7.3.3 Procedure

The data used in this Study is secondary data derived from the original Q Factor Analyses in Study One and Study Two (Part A). This study did not involve any additional data collection or participant involvement.

Through the routine Q Factor Analysis process using KENQ Analysis software (Banasick, 2018; 2019) Z-Scores for each statement are derived. Z-scores, or Normalised Factor Scores, represent a standardised method to measure how many standard deviations each statement in each factor array has been placed relative to the population mean. A Z-score can be placed on a normal distribution and is a method to compare results to a normal population. The Z-Score essentially gives a weighted average of the relevance and saliency of each statement to the overall factor array. The factor array is a representation of the average of how those statements were sorted by all those that loaded significantly on that factor.

4.7.3.4 Data Collection Materials

1. PC
2. KENQ Analysis software (Banasick, 2018; 2019).

4.7.3.5 Data Analysis

Using SPSS (v26) a Pearson (Bivariate) Correlation Analysis was undertaken to examine the strengths of the associations of the Z-Scores between the factor arrays derived from the two Factors at timepoints One, Two and Three and the factor arrays derived from the three Expert Factors.

This was achieved by the use of the prototype developed from the experts to compare to collective viewpoints at each approved premise as they progress through the Enabling Environment initiative. There is a logical supposition that staff views of the Enabling Environment culture will more aligned

with the Expert Enabling Environment culture the closer the environment is to being awarded the Enabling Environment status.

4.8 Ethical Considerations

Ethical review is an important and complex task. This project required ethical review and permission from three separate review panels; (1) the NHS Research Ethics Committee / HRA process (Nottingham 2 Research Ethics Committee) because a number of participants were NHS staff and a number of data collection sites were NHS locations; (2) The NOMS Ethical Review Procedure was undertaken consecutively to the NHS Ethics because the majority of the participants were National Probation Service staff and data collection sites were National Probation Service locations; and (3) ethical review was sought from the University of Roehampton Ethics Committee given this project is in assessment for an award of a Doctorate in Forensic Psychology. Ethical approval was sought and approved by each of these three panels independently before any data collection began (Appendix 7.1, 7.2 and 7.3). Similarly, permission was sought from the authors / developers of the two psychometric questionnaires used in this study (Appendix 8.1 and 8.2), i.e. The EssenCES Questionnaire (Schalast, 2008) and The Working Alliance Inventory (WAI; Horvath, 1982; Horvath, & Greenberg, 1989).

Each participant was given the relevant Information Sheet (Appendix 9.1 and 9.2) to read and were given the ability to ask questions before any involvement in the research. Informed consent was then gained for all participants involved in the research. Participants were provided with relevant instructions for their respective involvement in the study (Appendix 10.1 and 10.2). Participants involved in the research were assigned a research number and details were removed to maintain confidentiality. Data was stored in secure filing cabinets, on a secure NHS Server or on a password

protected and encrypted portable USB drive. All data collection, storage and management was compliant with the Data Protection Act (1998) and then GDPR requirements when these were implemented in May 2018.

There were a number of complex and interrelated aspects pertinent to the ethical review process for this research. Alongside the ethical review process, which is a national process, permission to undertake the research, to be able to access each specific site and to be able to invite participants to take part was also sought from Regional Senior Management in the National Probation Service. Also, regarding the approved premises, permission was sought from local Senior Management and site-specific Team Managers at each time point when data was collected. Methodologically, this caused a number of complexities and time delays in the ability to access approved premises according to the original data collection schedule because of live staffing, resource and incidents regarding difficult and dangerous residents.

An important reflection of the ethical review process surrounded the safeguarding of both staff and residents within the approved premises. Careful planning and a process for information sharing was considered for the potential situation whereby a staff member discussed unprofessional or harmful behaviour to the vulnerable residents, or indeed expressed that they were at risk themselves of psychological or physical harm. Thankfully this did not occur. Similarly, the participants were encouraged to explore their experiences of the Enabling Environment and the general climate in the approved premise through the post card sort interviews. This meant that careful considerations were made to allow this anonymous and confidential space to maintain empirical utility, but whilst also being transparent about what information could and would be shared if discussed. Explaining how I would create an environment where openness and research robustness could be maintained whilst also ensuring that anything disclosed would not impact their employment or relationships with peers was a complex process to explain within the ethics review process. A further

methodological complexity surrounded being clear and transparent about willingness and consent to take part in the research, and how information about those who did not participate was maintained confidential and independent to the process. Whilst planning for as many participants as possible to be involved through an open consenting process, awareness was given to the potential for social pressure to participate if peers in the approved premise have been involved, and awareness to managing participant rights when individuals did not wish to be participants. Furthermore, it is possible that my presence as a researcher may have influenced participants to take part in the research process by the fact that I was present in the approved premises at varying points undertaking the data collection.

4.9 Reflective Account

Given the rich qualitative nature of this research, it is important to include some reflective thinking about the research design, implementation and analysis. This study uses Q Methodology which underpinned by the empirical position of social constructionism. As such, the research involves an inquiry into the social and interpersonal meaning of what a staff at specific approved premises thought about their therapeutic culture and milieu. Although Q Methodology is well suited to understanding the collective viewpoints of individuals within the context being studied, it is not without potential influence from the researcher, especially with regard to the possible personal and professional assumptions, preferences and interpretations within the research process. This is especially so given it is widely understood that through qualitative methods there are multiple possible assumptions, meanings and empirical paradigms available, and as such multiple possible interpretations of the data presented.

The aim, foremost, was to allow the participants to share their idiographic voices through the data collection process, and to minimise where possible the potential influences that the researcher's prior clinical experiences and inevitable biases may have had. The researcher had an awareness as a psychologist, clinician and researcher that he has diverse experience in working psychologically within complex forensic therapeutic environments, treatment cultures and within milieu-based therapeutic environments. He also has experience of working within approved premises, and therefore understood the inherent complexities of the role, purpose and function of these environments. The researcher considered his clinical and personal experiences of working in such environments and was aware that these may have influenced what he would both expect and would ideally like to see unfold in the research. As such the researcher held optimistic assumptions of the journey that the staff would experience and achieve through the research process. Similarly, and in contrast, the researcher also held a perspective about how challenging it would be, as a process, to develop, implement and maintain a therapeutic culture such as an Enabling Environment within an approved premise. This idea, as well as others was however thought about regularly in clinical and academic supervision throughout the research to enhance reflexivity.

An important empirical reflection surrounded the process of undertaking the Concourse for this research. Through this Concourse process it was important for the researcher to robustly explore the wide-ranging academic, empirical and published literature, as well as integrate qualitative information from focus groups and his own clinical experiences. This therefore adds a layer of subjectivity in both the methodology of gathering the qualitative data, and in the conscious and unconscious application of their experience to what was relevant in this process. In order to attempt to address this potential bias, the researcher also used supervision to reflect on this process, and more importantly the more formalized qualitative methodology of Thematic Analysis was used to apply structure and process to organizing, interpreting and applying meaning to the information available.

Within the process of the data collection, predicaments were observed by the researcher around a number of the participants, especially at Time Two, who experienced a dilemma in offering their time to be involved in the research and in managing the demands that were placed on them in their role within the approved premise. Here, at times the researcher recognized that he had to make a choice to balance the need for the participant to return to their role with the need for robust and comprehensive qualitative information, particularly within the post card sort interviews. Also, with regard to the participants actually taking part in the project, although the researcher attempted to overtly maintain an objective and independent position, i.e. making it explicit that he was not employed by the service responsible for the approved premises or for developing Enabling Environment, he was employed by the NHS Trust supporting the approved premises to implement this therapeutic environment. The researcher made attempts to address this by involving approved premises in the research that had no prior clinical contact with the researcher to minimise this influence as much as possible. Notwithstanding, the researcher could well have prompted participant engagement in the research by instilling a wish to please or satisfy the researcher, or to acquiesce to the direction of management, who in turn may have felt that they are obliged to facilitate and encourage their staff members to take part. However, through the data collection process it did not come to the researcher's awareness that participants took part reluctantly. In fact, on reflection, one participant who initially declined to take part in the research changed their mind and contacted the researcher wishing to be part of the study when they were informed again by another colleague that he was fully independent from the approved premise where they worked, and from the National Probation Service.

With regard to the analysis and interpretation of the data from the card sorts, the researcher was mindful that they were likely incorporating their experience from working in forensic mental healthcare settings to their understanding of the findings. This was an important reflexive process,

especially the consideration of the view that the staff who were relatively inexperienced in psychologically informed practice were expected to engage complex service users in a therapeutic process within a multifaceted risk management and relationship-based framework. This was further complicated by the paucity of literature relating to psychological practice within such environments, and as such was also thought about in supervision.

Finally, throughout the research process, what struck the researcher was an awareness of the resilience, flexibility and dedication of the staff at the approved premises to be able to engage in a difficult role through a complicated organisational change and overt shift in their clinical practice. This sense of perseverance of the staff teams observed by the researcher was also discussed in supervision to reflect on how it may have influenced how he interpreted and assimilated the shared perspectives of the staff in the research.

Chapter Five:
Study One – Expert Participants

5. Results: Expert Participants

5.1 Overview

The research objectives for this Study are to explore expert's perspectives on Enabling Environments to understand what the shared perspectives are around such environments. Q-Methodology helps to effectively explain complex socially constructed viewpoints from the point of view of the participants (Watts & Stenner, 2003) without setting specific hypotheses it allows for the exploration of a sense of coherence by asking participants to decide what is meaningful and therefore what is significant from their perspective (Watts & Stenner, 2005; 2012).

The aims of Study One are twofold. Firstly, the objective is to explore the shared viewpoints of what might construct an ideal Enabling Environment by participants who are regarded as being 'experts' in both Enabling Environments and therapeutic environments / milieu. These participants are defined in Chapter Four. Secondly, through the Q-Analysis process, the objective is to create a "prototype" or ideal Q-Sort (set of ranked statements) to use for comparative analysis in Study Two (Part B). This prototype or gold standard Q-Set will be compared with the data at each timepoint via correlational analyses to explore if there are any changes in the participants perception of the Enabling Environment across time.

There are three basic aspects to the process of analysis in Q-Methodology. These are;

1. Moving from Q-Sorts to extracting raw Factors
2. Translating significant raw Factors that are extracted into Factor Arrays

3. Using the Factor Arrays to inform the qualitative interpretation of the Factors.

Moving through these basic phases was undertaken using an abductive process, i.e. the analysis and interpretation process was data driven to attempt to provide the best possible theoretical and psychological meaning to the data by defining each factor. This approach is believed to be inherently more rigorous and to preserve the integrity of the data, ensuring that the common viewpoints shared by the participants (Risdon et al., 2003) are explored, and to define aspects of mutual coherence (Brouwer, 1999) in the data.

5.1.1 Software

KEN-Q Analysis (Banasick, 2018; 2019) was used to analyse the data from 21 Q-Sorts to identify the patterns and commonalities between the participants. It was chosen because of being freely available from https://shawnbanasick.github.io/ken-q-analysis/, its compatibility with multiple computer platforms (i.e. PC and MAC) and a preferable user interface. PQMethod software (Schmolck, 2002) or PCQ for Windows (Stricklin & Almeida, 2004) are examples of alternative options.

5.1.2 Data Entry

The first stage of the data interpretation process is to input the relative placements of the 50 statements for each of the 21 Q-Sorts into an Excel spreadsheet specifically designed for KEN-Q Analysis. This data entry process was double-checked, and finally this spreadsheet was inputted into KEN-Q Analysis and the analysis performed.

5.2 Q Analysis

5.2.1 Factor Extraction

Extracting factors from the Q-Sort is a process of reducing the data in a meaningful and interpretable manner. The process of Q-Factor Analysis aggregates together the groups of participants who share and express a similar viewpoint. If participants have similar ways of sorting the statements in the Q-Sort then it can be inferred that they share similar subjective viewpoints. It is the collation of these similar viewpoints, that when taken together in a holistic or gestalt manner form the factors that are extracted. For example, from the 21 participants in this Study, three Factors were extracted and used for interpretation, therefore meaning that there were three distinct and meaningful patterns that the participants sorted their statements into.

The first stage in factor extraction is to undertake a correlation analysis. KEN-Q Analysis creates a correlation matrix (using Pearson's r Coefficient) outlining the degree that each participant is similar or different to each other participant (Brown, 1980). The correlation matrix for the Expert Sorts (Appendix 11) demonstrates the relationships between the 21 Q-Sorts used in this study.

The next stage is to perform the By-Person Factor Analysis and to identify the meaningful and interpretable factors. The 21 Q-Sorts were inter-correlated and subject to the By-Person Factor Analysis using the dedicated computer package, KEN-Q Analysis. A Centroid Factor Analysis was used followed by the Varimax Rotation method to generate possible factor solutions. The data analysis process has been discussed in full in Chapter Four.

Of note, minor Manual Rotations were attempted within the analysis to try to maximise the number of participants that significantly load on any one factor (+/- up to 90° in 10° increments), however any Manual Rotations that were undertaken did not increase the interpretability of the data.

Brown (1980) suggested researchers begin to explore factors by initially extracting seven factors, however Watts and Stenner (2012) suggest a starting point of extracting one factor for every six Q-Sorts in the study. Because of the number of participants in this analysis (N=21), I started by extracting a four-factor solution. Factor solutions for two to five Factors were computed for thoroughness. Table 6 below provides a quantitative summary of the factor solutions.

Table 6. Summary of the Different Possible Factor Solutions for the Experts

Factor Solution	No. of Factors with Eigenvalue >1	No. of Factors meeting Humphrey's Rule	No. of Factors with Two significantly loading participants	Total No of participants accounted for in the solution	No. non-significant / confounding Participants	Amount of Variance Explained
Two	2	2	2	15	6	30%
Three	2	2	2	15	6	31%
Four	**3**	**3**	**3**	**12**	**9**	**36%**
Five	3	3	3	12	9	36%

When deciding on the best solution to most effectively represent the data, consideration in the analysis was given to the following six aspects;

a) The Kaiser-Guttman Criterion.

b) Humphrey's Rule.

c) The number of significantly loading Q-Sorts on each Factor.

d) The amount of variance explained by the solution.

e) Demographic information

f) Additional qualitative information obtained from the post Card Sort Interviews.

Taking each of these in turn; (a) The Kaiser-Guttman Criterion outlines that a Factor can be regarded as significant and as such meaningful if the Eigenvalue is > 1 (McKeown & Thomas, 1988). Regarding (b), Humphrey's Rule identifies a Factor as being significant if the cross product of the two highest Factor Loadings is greater than 2x Standard Error (SE) (Watts & Stenner, 2012). SE is calculated by the following formula (Watts & Stenner, 2012);

SE = (1 ÷ √ Number of items in the Q-Set), or

SE = (1 ÷ √ 50) = 0.14.

Therefore, a Factor is found to meet the criteria for Humphrey's Rule and can be regarded as being a significant Factor if the cross product of the two highest Factor Loadings is greater than 0.28 (i.e. 2 x SE). A working example from the two highest Factor Loadings from Factor 1 (in Table 8 below) is as follows;

0.75 x 0.7145 = 0.53,

0.53 > 0.28, therefore meets Humphrey's Rule.

As can be seen from Table 6 above, with the two-factor solution both the Factors extracted had Eigenvalues > 1 and met Humphrey's Rule. The explanation of why this solution was not used is detailed below. With the three-factor solution only two Factors had significant Eigenvalues and met Humphrey's Rule; and with both the four and five-factor solutions, both options resulted in only three Factors with Eigenvalues > 1 and which met Humphrey's Rule. The process of a factor analysis is to reduce and simplify the data, so factors with Eigenvalues < 1 do not contribute to an effective reduction in the data.

Regarding (c), Watts and Stenner (2012) state that there must be a minimum of two participants who load significantly on each Factor to be able to meaningfully interpret that Factor. To calculate the value of the significantly loading Q-sorts, McKeown and Thomas (1998) outline that statistical significance at the $P < 0.01$ level is indicated by Factor Loadings that are 2.58 times greater than the SE, i.e. greater than ±0.36. To calculate this the following formula was used;

SE = (1 ÷ √ Number of items in the Q-Set)

Therefore;

2.58 x (1 ÷ √ Number of items in the Q-Set), or

2.58 x (1 ÷ √ 50), or

2.58 x (0.14) = ± 0.36

As you can see from Table 6 above, with the two-factor solution both of the Factors extracted had more than two participants significantly load (i.e. Factor Loading > ± 0.36) on each of the two Factors. However, the three-factor solution resulted in only two Factors with more than two participants significantly loading; and similarly, the four and five-factor solutions both had participants significantly load on only three of the Factors.

Regarding (d), variance is understood as the "proportion of the meaning and variability in a Q sort or study that is held in common with, or by, the group" (Watts & Stenner, 2012, p. 98). Essentially, the greater the level of explained variance demonstrated by the Factors extracted means that the analysis has been more effective in identifying what meaning the Q-Sorts have in common. Watts and Stenner (2012) state that a total study variance of greater than 35% should be considered

sound. From Table 6 above, the four and five-factor solutions explain the greatest amount of variance compared to the other factor solutions.

Alongside the above considerations given to extracting Factors, it was also important to qualitatively explore the data to try to determine what factor solution was more representative of the data. This was done by qualitatively reviewing the Post Card Sort Interviews and considering the demographic information that the Factors were constructed from. From this process it was decided that there were sufficient distinctions in the data to justify the retention of three Factors from the four-factor solution. Retaining the three Factors was more representative of the data and would allow for a more thorough and informative account. Table 7 below outlines the relative significance of each of the four Factors extracted from the four-factor solution.

Therefore, in regard to the final factor solution, a three -factor solution was found to be most representative of the data, and as such three Factors were retained for the analysis. Together, these three factors explained 36% of the variance. 12 of the 21 Q-Sorts loaded significantly over these three factors, i.e. with a loading of ±0.36 being significant at the $p < 0.01$ level. Five Q-Sorts were found to be non-significant and four were confounding.

Table 7. Significance Values of the Four Unrotated Factors Extracted for the Experts

	Factor 1	Factor 2	Factor 3	Factor 4
Eigenvalues	4.35	1.87	0.22	1.27
Humphrey's Rule	0.53	0.38	---	0.34
Number of Q-Sorts Loaded	4	4	0	4
% Explained Variance	21	9	1	6

In giving consideration to each of the six aspects outlined above, a two and three factor solution was not decided upon because both these solutions yielded two Factors, that through qualitative review were not thought to be most representative or best explained the data when compared to the four-factor solution which yielded three usable Factors that each made an original contribution to understanding the data. Also, the two and three-factor solutions explained markedly less variance than the four-Factor solution. The five-factor solution that yielded three usable Factors had comparable explained variance to the four-factor solution, but there were two Factors that did not have any significant factor loadings, and thus did not holistically reflect a best fit of the data.

The four-factor solution, yielding three extractable and usable Factors was chosen because; (1) it maximised the explained variance, (2) it minimised the number of Factors without any significant factor loadings, (3) each of the usable factors met the Kaiser-Guttman Criterion and Humphrey's Rule, and (4) the data qualitatively best represented the data and each Factor extracted made an original contribution to understanding the data.

Therefore, regarding the final factor solution, a four-factor solution that yielded three interpretable Factors was found to be most representative of the data, and as such three Factors were extracted and retained for the analysis. Together, these three Factors explained 36% of the variance. 12 of the 21 Q-Sorts loaded significantly over these three Factors, i.e. with a loading of ±0.36 being significant at the $p < 0.01$ level. Five Q-Sorts were found to be non-significant and four were confounding.

Table 8 below demonstrates the factor loadings for the three factors extracted.

Table 8. Rotated Factor Loadings for Expert Participants

Q sort	Factor A	Factor B	Factor C
E1	0.3393	-0.0391	-0.2544
E2	0.5637	0.595	0.0055
E3	0.4896	0.0677	0.4418
E4	0.4135	0.5214	-0.0726
E5	0.0562	0.342	**0.663***
E6	**0.3774***	0.1001	0.2161
E7	0.1757	0.2892	**0.5135***
E8	-0.0853	**0.6543***	0.1811
E9	0.0116	-0.0901	0.3449
E10	-0.1089	**0.5521***	0.1177
E11	0.2194	**0.5129***	-0.0311
E12	-0.1307	0.3492	**0.409***
E13	0.2885	**0.578***	0.1325
E14	0.3088	-0.0918	0.2778
E15	0.0382	0.3134	-0.0041
E16	0.483	0.5459	0.056
E17	**0.7145***	0.0381	-0.0659
E18	**0.75***	0.0488	0.0701
E 19	0.0169	0.0056	**0.4805***
E20	**0.5823***	0.193	-0.0127
E21	0.3422	0.1352	0.1485
Eigenvalues	**3.15**	**2.73**	**1.68**
Explained variance (%)	**15**	**13**	**8**

Note: (*) denotes the participants that loaded significantly on each Factor.

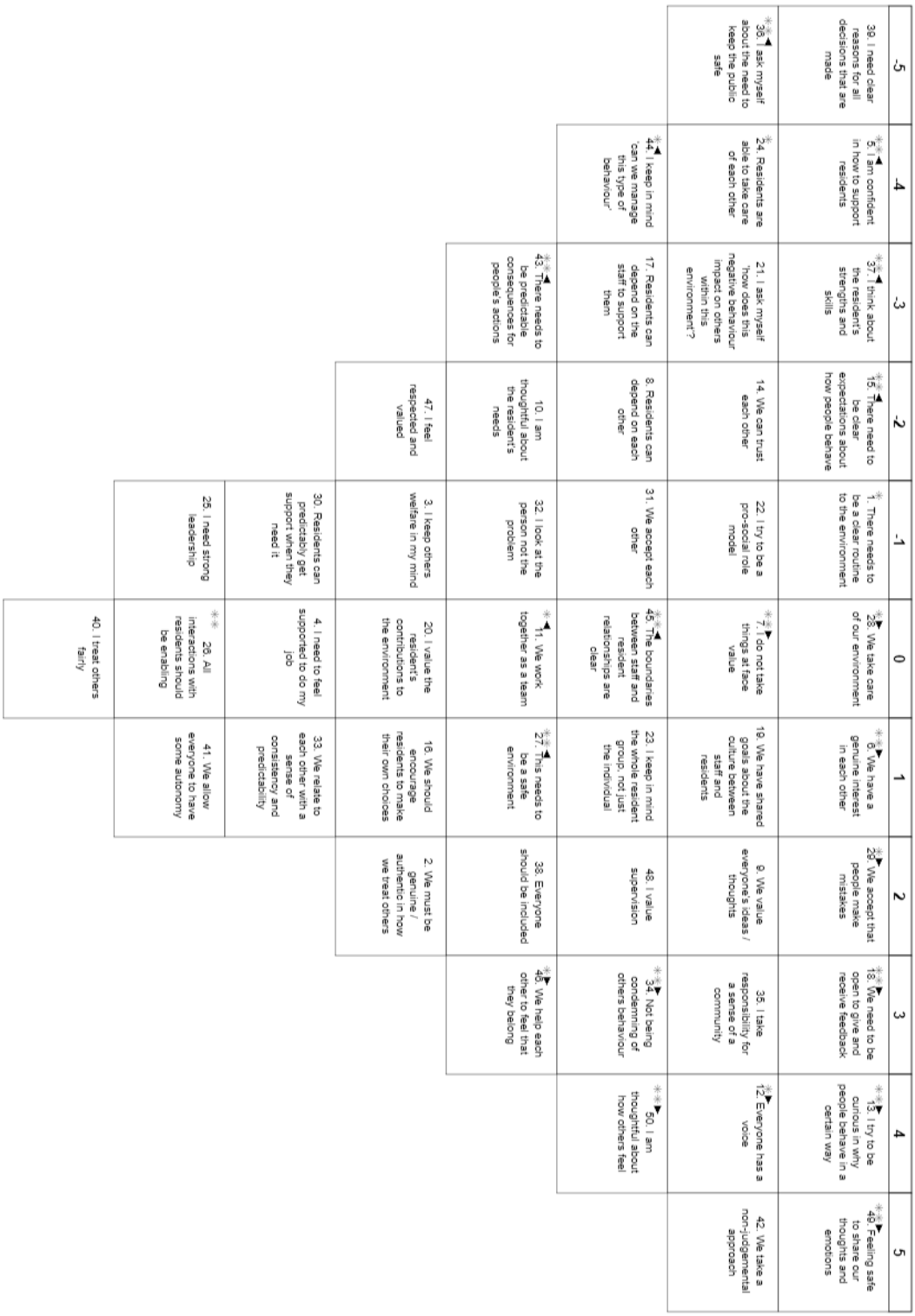
5.2.2 Factor Arrays

The next stage in the analysis is to define the factor arrays. Each of the Q-Sorts that were not significant or were confounding were excluded from developing the factor array. Even though the nine confounded or non-significant Q-Sorts were not included within the actual factor arrays, they were still considered in the interpretation of the Factors to try to safeguard that nothing of value

was lost from the data analysis given this methodology aims to hear the subjective perspectives of the participants.

All Q-Sorts (i.e. participants) that significantly load on the same Factor are suggested to be those that share similar patterns in the way that they sort the statements. Subsequently, for example, each of the four Q-Sorts exemplifying Factor A can be assured to share a distinct understanding of the subject matter. The factor exemplars are merged to form a single ideal Q-Sort for each factor called a factor array. A factor array is calculated according to the procedure of weighted averages, i.e. higher loading exemplars (those with high factor loadings) are given more weight in the averaging process since they better exemplify the factor. Because a factor array is a merged average of each of the Q-Sorts that significantly load on that factor it reflects a single complete Q-Sort. Figure 1 below exemplifies the factor array for Factor A. Factor Arrays for the Factor B and C can be found in (Appendix 12.1 and 12.2).

Figure 1. Displaying the Visual Factor Array for the Statements for Factor A (*The Safe Relating Space)*



Alongside the visual representation of the separate factor array for each Factor, Table 9 below demonstrates the relative rankings given to each statement within each Factor. Essentially, it shows how the participants, when their rankings were combined and averaged through the analysis, rank each of the statements on each factor. For example, Statement 27 "This needs to be a safe environment" was ranked at +1 on Factor A and +5 on Factors B and Factor C. This then can begin to tell us that a sense of safety was regarded as being very important to the viewpoints of the participants loading on Factor B and C but was less salient to the perspectives of those loading in Factor A.

Table 9. Factor Arrays for Each of the Three Expert Factors.

	Statements	Factor A	Factor B	Factor C
1	There needs to be a clear routine to the environment	-1	3	-3
2	We must be genuine / authentic in how we treat others	2	1	1
3	I keep others welfare in my mind	-1	-1	0
4	I need to feel supported to do my job	0	-4	-1
5	I am confident in how to support residents	-4	1	-1
6	We have a genuine interest in each other	1	-4	-4
7	I do not take things at face value	0	-2	-3
8	Residents can depend on each other	-2	-4	-5
9	We value everyone's ideas / thoughts	2	3	0
10	I am thoughtful about the resident's needs	-2	-1	0
11	We work together as a team	0	4	2
12	Everyone has a voice	4	2	0
13	I try to be curious in why people behave in a certain way	4	-3	2
14	We can trust each other	-2	0	-2
15	There need to be clear expectations about how people behave	-2	4	5
16	We should encourage residents to make their own choices	1	2	0
17	Residents can depend on the staff to support them	-3	3	-2
18	We need to be open to give and receive feedback	3	2	0
19	We have shared goals about the culture between staff and residents	1	0	1
20	I value the resident's contributions to the environment	0	0	-1
21	I ask myself 'how does this negative behaviour impact on othe within this environment'?	-3	0	-3
22	I try to be a pro-social role model	-1	1	4
23	I keep in mind the whole resident group, not just the individua	1	-2	1

24	Residents are able to take care of each other	-4	-5	-1
25	I need strong leadership	-1	-1	0
26	All interactions with residents should be enabling	0	3	-4
27	This needs to be a safe environment	1	5	5
28	We take care of our environment	0	-3	-1
29	We accept that people make mistakes	2	-2	0
30	Residents can predictably get support when they need it	-1	0	-1
31	We accept each other	-1	-2	-4
32	I look at the person not the problem	-1	-3	-2
33	We relate to each other with a sense of consistency and predictability	1	0	1
34	Not being condemning of others behaviour	3	-1	-5
35	I take responsibility for a sense of a community	3	-1	3
36	I ask myself about the need to keep the public safe	-5	1	3
37	I think about the resident's strengths and skills	-3	0	2
38	Everyone should be included	2	2	-1
39	I need clear reasons for all decisions that are made	-5	-5	-2
40	I treat others fairly	0	0	4
41	We allow everyone to have some autonomy	1	1	1
42	We take a non-judgemental approach	5	4	1
43	There needs to be predictable consequences for people's acti	-3	2	2
44	I keep in mind 'can we manage this type of behaviour'	-4	-2	-2
45	The boundaries between staff and resident relationships are c	0	5	4
46	We help each other to feel that they belong	3	1	-3
47	I feel respected and valued	-2	-3	3
48	I value supervision	2	-1	3
49	Feeling safe to share our thoughts and emotions	5	1	2
50	I am thoughtful about how others feel	4	-1	1

5.2.3 Relationship between the Factors

Table 10 below details the correlational scores between the three Factors derived from this analysis. The Q-Analysis revealed that although there are three distinct and separate viewpoints described by the participants, there is a marginally closer relationship between Factors B and C than can be seen in the interrelationships of other two Factors. This tells us that Factor A is more independent and distinct from Factors B and C, and although Factors B and C have a moderate

correlation score, they remain as distinct independent viewpoints as there were sufficient differences in the findings for the three-factor solution to be selected for interpretation.

Table. 10. Correlations Between Factor Scores for the Three Expert Factors

	Factor A	Factor B	Factor C
Factor A	1		
Factor B	0.1716	1	
Factor C	0.1064	0.4417	1

5.3 Interpretation of the Factors

5.3.1 Overview

A narrative style as defined by Watts and Stenner (2012) was used as this process helps to investigate the subtler nuances within the factors to be identified and emphasised. As described above, because participants sort the statements according to the psychological significance they place on them (Stenner et al., 2008), it is assumed that every placement holds meaning and importance. Therefore, the interpretation of each of the factor arrays takes four elements into consideration; (1) the reflection of the entire item configuration, not just the statements at the extreme ends; (2) incorporation of the distinguishing and consensus statements as they show which statements within each factor array have been placed in a significantly different place to the other factors, therefore demonstrating how the factor is unique; (3) the demographics of the participants loading on each Factor; and (4) consideration to the qualitative comments provided by the participants who load on each of the Factors in order to more holistically understand the reasoning behind the sorting process. A 'Crib Sheet' approach was used as a guide to help with identifying the salient placement of statements by the participants and to help reflect on the relative rankings of

these statements suggested (Watts & Stenner, 2012). The Crib Sheet for Factors A, B and C can be found in Appendix 13.1, 13.2 and 13.3. The consensus Statements can be found in Appendix 13.4.

5.3.2 Factor A: The Safe Relating Space

Factor A has an Eigenvalue of 3.15 and explains 15% of the study variance. Four participants are significantly loaded on this Factor with two of these being Psychologists and two Psychiatrists. No participants are actively working within an approved premise but do actively practice within therapeutic environments. Three of these are male, one is female; the mean age of the participants is 53.3 years; and the average time working within therapeutic environments is 105 months.

This Factor essentially represents the importance of an emotionally safe environment where residents are able to share their thoughts and emotions with each other, and where relating to others and the value in building interpersonal relationships is key to a safe and effective environment. This is delivered through creating a sense of a shared community and togetherness where individuals feel they have a voice to be able to contribute to the shared goals within the environment.

The narrative that these participants share in this factor surround there needing to be a sense of feeling safe to share thoughts and feelings with each other (49; 5) without great importance placed to create an environment where individuals are safe from physical threat from each other (27; 1). Although clear trust in each other (14; -2) is not required, there needs to be an environment where all can be curious in thinking together in the way that people behave interpersonally (13; 4), everyone's ideas are valued (9; 2), all should be included and encouraged to feel that they belong (38; 2, 46; 3) and in being thoughtful about the way that people feel (50; 4).

Similarly, it is also central to take a non-judgemental and non-condemning approach to the way that people behave and relate to each other (42; 5, 34; 3), there being a recognition that the residents can make genuine mistakes (29; 2) and in being genuine and authentic in relating to each other (2; 2). Similarly, the staff are open and accepting to give and receive feedback with residents and encourage this with the residents (18; 4), as well as allowing the residents to feel that they have a voice in the shared therapeutic process (12; 4).

Although there is not a primary focus that all interactions need to be enabling or in the need for a clear teamwork approach (26; 0, 11; 0), there is some value placed in the need for shared goals between residents and providers (19, 1). The participants express that it is integral to take responsibility for developing and implementing a sense of community (35; 3) as residents should neither solely be dependent upon staff for their needs (17; -3) or only able to take care of each other (24; -4). This concept of relatedness to each other and sense of interpersonal community relationships is also exemplified in the way that thinking through individual strengths and skills (37; -3) is not thought as important, as well as there not being a primary focus on taking care of the physical environment (28; 0).

What is also present in the narrative of this Factor is that, although there needs to be an element of clear boundaries between staff and residents (45; 0), it is not essential to feel a sense of confidence in how to support others (5; -4) and there does not necessarily need to be clear expectations for how people behave (15; -2) or for clear routines (1; -1). There is also not a sense that there can be clear predictable consequences for peoples' actions (43; -3). The participants do not seem to need to have to need a clear sense of logic for decisions being made (39; -5).

Furthermore, the need to think about public protection (36; -5) and managing problematic or risky interpersonal behaviour (44; -4) is not thought to be a salient construct of this Factor, and neither

is asking questions linked to whether a problematic behaviour can be managed in such an environment (21; -3).

Table 11 below outlines the distinguishing statements for Factor A.

Table 11. Distinguishing Statements for Expert Factor A (The Safe Relating Space)

Statement Number	Statement	Factor A Q-SV	Factor A Z-score	Factor B Q-SV	Factor B Z-score	Factor C Q-SV	Factor C Z-score
49	Feeling safe to share our thoughts and emotions	5	2.14*	1	0.427	2	0.663
13	I try to be curious in why people behave in a certain way	4	1.55*	-3	-1.147	2	0.662
12	Everyone has a voice	4	1.53	2	0.743	0	-0.302
50	I am thoughtful about how others feel	4	1.52*	-1	-0.611	1	0.325
18	We need to be open to give and receive feedback	3	1.46*	2	0.475	0	-0.073
34	Not being condemning of others behaviour	3	0.98*	-1	-0.678	-5	-1.593
46	We help each other to feel that they belong	3	0.93	1	0.235	-3	-1.063
29	We accept that people make mistakes	2	0.89	-2	-0.959	0	0.028
6	We have a genuine interest in each other	1	0.45*	-4	-1.218	-4	-1.366
27	This needs to be a safe environment	1	0.34*	5	2.759	5	2.017
28	We take care of our environment	0	0.27	-3	-1.155	-1	-0.539
7	I do not take things at face value	0	0.15*	-2	-0.9	-3	-1.115
45	The boundaries between staff and resident relationships are clear	0	0.15*	5	2.082	4	1.528
11	We work together as a team	0	0.13	4	1.889	2	0.84
26	All interactions with residents should be enabling	0	-0.13*	3	0.809	-4	-1.489
1	There needs to be a clear routine to the environment	-1	-0.32	3	1.134	-3	-1.127
15	There need to be clear expectations about how people behave	-2	-0.73*	4	1.284	5	2.142
37	I think about the resident's strengths and skills	-3	-0.92*	0	0.121	2	0.578
43	There needs to be predictable consequences for people's actions	-3	-1.15*	2	0.635	2	0.914
5	I am confident in how to support residents	-4	-1.3*	1	0.404	-1	-0.4
24	Residents are able to take care of each other	-4	-1.32	-5	-2.024	-1	-0.504
44	I keep in mind 'can we manage this type of behaviour'	-4	-1.67	-2	-0.922	-2	-0.835
36	I ask myself about the need to keep the public safe	-5	-2.49*	1	0.45	3	1.229

Note: $p < 0.05$; * indicates significance at $p < 0.01$

The following additional qualitative information is contained in the discourse from the post card sort interviews. This data further defines the salient notions and themes that underpin this Factor. For example;

> *"feeling safe to share our thoughts and emotions is fundamental in relationships with others…. Feeling safe to share avoids a defensive non-trusting environment and non-trusting relationships… it is dynamic and can be fluctuating although it needs to be predictable and dependable… The principal is in the community and the network of the relationships, this is the key and the core element…. The network of relationships is the quintessence of an enabling environment…. The quality of the relationships is essential".*
>
> (Participant E17)

> *"The most important elements are this idea of shared values… Individuals having a voice… about being non-judgemental and non-condemning, but also thinking about staff welfare and being curious about what is in people's minds".*
>
> (Participant E18)

> *"…. everyone has a voice, everyone has to be caring for each other. It is about seeing each other and validating each other so that everyone's needs are facilitated... Equal say means equal value… it is about being together, having shared goals and being invested in the diversity, looking out for each other. It is about genuinely saying that everyone has a voice and working out that everything fits together in place".*
>
> (Participant E20)

"…an enabling environment is about the relational security. Relationships is the key to understanding individuals and understanding risk. The enabling environment is more sophisticated than just risk management".

(Participant E17)

5.3.3 Factor B: The Predictable System

Factor B has an Eigenvalue of 2.73 and explains 13% of the study variance. Four participants are significantly loaded on this Factor with three of these being Offender Supervisors actively working within approved premises and one Approved Premise Manager. Three of these are female, one is male; the mean age of the participants is 43.3 years; and the average time working within therapeutic environments is 82.3 months.

The nature of this Factor relates to a focus on how the staff team predictably manage interpersonal behaviours and create an environment that is safe from physical threat for staff and residents. This is established through holding clear interpersonal boundaries, offering routine and structure as well as clear expectations of others. Value is also placed on including others, valuing their ideas and offering autonomy.

The views that the participants share in this Factor relate to the need for it to be a safe environment where individuals are safe from physical threat from each other (27; 5) rather than a space to safely share thoughts and emotions (49; 1). The boundaries between staff and residents of the therapeutic environment are clear and well defined (45; 5), with a sense of needing a structure and routine (1; 3) and with clear expectations for how people behave (15; 4). There is less importance placed on overt consequences (43; 2) for difficult behaviours.

The need for a collective view of working together as a unified team (11; 4) is strongly expressed, although there a less value placed on supervision and support within the environment (48; -1) or feeling respected and valued by others (47; -3). There is some perspective that individuals need to feel confident to support others (5; 1) in the environment but the participants suggested that they do not need to feel supported to undertake their roles (4; -4) or do not need clear reasons for decision that are made (39; -5),

There is a strong agreement with and a shared understanding that interactions between staff and residents should be enabling where at all possible (26; 3) yet the participants expressed the view that being curious about how others behave in a certain way or thinking about the residents as a collective within the environment rather than as individuals themselves is not important (23; -2, & 13; -3). The participants identified that they themselves as staff should not take responsibility for implementing a sense of community (35; -1). There is a perspective present that individuals engaged in the therapeutic environment are not thought to be able to take care of or support each other (24; -5) but that they can depend on the staff working with them to support them (17; 3). Furthermore, the participants identified that some consideration needs to be made as to whether problematic behaviours can be managed in such an environment (21; 0) and there can be a focus on dealing with problems and managing problematic behaviours in the environment rather than understanding why people behave in a certain way (32; -3). Being non-judgemental in their approach is important to the participants (42; 4).

Residents are included and valued within the environment (38; 2, 9; 3), there is some trust and support for them to demonstrate autonomy in their actions and encouragement to make their own choices (16; 2, 41; 1), and they are offered a voice to contribute to the environment (12; 2). There is also a need to be open to give and receive feedback (18; 2). However, the need to have a genuine interest in each other interpersonally (6; -4) or the notion of being thoughtful about others and

their needs (50; -1) is not salient. Furthermore, participants suggest that in this Factor they are less accepting that individuals do make mistakes (29; -2) and behaviours can at times be condemned (34; -1).

Table 12 below outlines the distinguishing statements for Factor B.

Table 12. Distinguishing Statements for Expert Factor B (The Predictable System)

Statement Number	Statement	Factor A Q-SV	Factor A Z-score	Factor B Q-SV	Factor B Z-score	Factor C Q-SV	Factor C Z-score
27	This needs to be a safe environment	1	0.34	5	2.76	5	2.017
11	We work together as a team	0	0.13	4	1.89*	2	0.84
15	There need to be clear expectations about how people behave	-2	-0.73	4	1.28	5	2.142
1	There needs to be a clear routine to the environment	-1	-0.32	3	1.13*	-3	-1.127
17	Residents can depend on the staff to support them	-3	-1.1	3	0.92*	-2	-0.675
26	All interactions with residents should be enabling	0	-0.13	3	0.81*	-4	-1.489
12	Everyone has a voice	4	1.53	2	0.74	0	-0.302
36	I ask myself about the need to keep the public safe	-5	-2.49	1	0.45	3	1.229
5	I am confident in how to support residents	-4	-1.3	1	0.4	-1	-0.4
46	We help each other to feel that they belong	3	0.93	1	0.24	-3	-1.063
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	-3	-0.98	0	0.14*	-3	-1
48	I value supervision	2	0.86	-1	-0.18*	3	0.925
50	I am thoughtful about how others feel	4	1.52	-1	-0.61*	1	0.325
34	Not being condemning of others behaviour	3	0.98	-1	-0.68*	-5	-1.593
35	I take responsibility for a sense of a community	3	0.99	-1	-0.74*	3	1.352
23	I keep in mind the whole resident group, not just the individual	1	0.41	-2	-0.9*	1	0.239
29	We accept that people make mistakes	2	0.89	-2	-0.96*	0	0.028
13	I try to be curious in why people behave in a certain way	4	1.55	-3	-1.15*	2	0.662
4	I need to feel supported to do my job	0	-0.04	-4	-1.3	-1	-0.576
24	Residents are able to take care of each other	-4	-1.32	-5	-2.02	-1	-0.504

Note: p<0.05; * indicates significance at p < 0.01

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this Factor. For example;

> *"It needs to be a safe and caring environment. There are basic human needs that need to be met and somewhere there needs to be support and the ability to help individuals to better themselves… it can be counterproductive if residents are left to their own devices. There needs to be a third party involved to ensure that the process is safe".*
>
> (Participant E8)

> *"An enabling environment needs to be a team to get the best result…. everyone, the whole team, residents and staff make up the environment. Feeling safe is really important, it is the nature of people to enable the residents and staff to be safe within that environment… Can we think about this in the environment, can we manage this behaviour in the environment? It is always in my mind. It is always built in…".*
>
> (Participant E10)

> *"We need to be able to trust to feel safe, to be honest about our environment and what's going on… we need to share and there needs to be boundaries to build up this… we need to be honest about our environment and what's going on… In order to feel safe we need to share and there needs to be boundaries to build up this trust… the need to keep the public safe is really important, but an enabling environment doesn't do this directly… they are less likely to offend and we are able to help them more".*

"Regarding needing clear decisions…. sometimes there can be a lack of genuine understanding of the process or a lack of genuine understanding of the outcomes of the clinical work that we do. Sometimes they just don't get it. It's a way of managing each other".

(Participant E11)

"… needing to be a safe environment, individuals need to feel safe to flourish, they need to be able to come to staff and to communicate and to be able to seek help. In relation to needing to work together, if we don't then we can't help each other. We can't help each other to keep things consistent and to have a shared approach".

(Participant E13)

5.3.4 Factor C: The Modelling Team

Factor C has an Eigenvalue of 1.68 and explains 8% of the study variance. Four participants are significantly loaded on this Factor with two of these being Psychologists, one Psychiatrist and one Approved Premise Manager. The Psychiatrist and one of the Psychologists are not actively working within an approved premise but do actively practice within therapeutic environments. The remaining Psychologist and Approved Premise Manager are actively working within an approved premise. Two participants are male and two are female; the mean age of the participants is 41.3 years; and the average time working within therapeutic environments is 51.5 months.

The nature of this Factor reflects a focus on how the staff team predictably manage behaviours and create an environment that is safe from physical threat for staff and residents whilst also creating

emotional safety to share thoughts and emotions. The exemplifying aspect of this Factor is that this safety is established through the development of an experience of community where staff offer support through being pro-social models.

The view that the participants express in this Factor relate to a need to have an environment where individuals are safe from physical threat from each other (27; 5) as well as in creating a sense of emotional or interpersonal safety to be able to share thoughts and emotions with each other (49; 2). The participants express the need for holding clear social and interpersonal boundaries between themselves and the residents (45; 4) in order to maintain this. There is also the need for clearly prescribed expectations about how residents behave socially and interpersonally (15; 5), but without any real importance placed on the need for routine (1; -3) and less need for the staff to provide consistency in their approach to deliver predictable consequences for negative behaviours (43; 2). This is consistent with the participants identifying that there is limited overt reflection needed about how negative behaviours impact the environment (21; -3) and that there is a distinct lack of a genuine interest in each other (6; -4).

The defining aspects that the participants express are the significance in taking responsibility for implementing a sense of community (35; 3) and the strong importance placed on the process of pro-social role modelling (22; 4). There is also an emphasis upon the need to consider elements of public protection and risk (36; 3) supported by teamwork being demonstrated by the staff (22; 2) and value placed in supervision with experienced colleagues (48; 3). There is some positive experience of collaboration and alliance experienced between the staff and the residents as goals about the culture of the environment in the approved premise can be shared between staff and residents (19; 1). Similarly, there is also some emphasis on thinking about strengths and skills of the residents (37; 2), in being thoughtful of others, being non-judgemental and being curious as to why people behave in a certain way (50;1, 42; 1 & 13; 2). It is however thought to be less necessary to

consistently value other's ideas and contributions within the environment or to be open to giving and receiving feedback (9; 0, 18; 0).

There is not the view held that all interactions should be enabling within the environment (26; -4) and there is limited emphasis in supporting residents to feel that they belong or including them within the social environment (46; -3, 38; -1). Residents are not viewed as being able to depend on each other (8; -5) or able to take care of each other (24; -1), and there is limited value in residents having a shared value in their contribution to the environment (12; 0). Likewise, staff often struggle to be openly accepting of the residents (31; -4) and they can at times take a judgmental and condemning approach to the resident's behaviours (42; 1, 34; -5).

Notwithstanding, there is an underlying expression that the participants should treat resident's fairly and offer parity (40; 4) and there remains some expression of a duty of care to the residents as the participants voiced the importance in holding in mind the general well-being and welfare of residents (3; 0). This thoughtfulness and consideration, although not held as a priority does also extend to some degree in understanding the resident's psychological and emotional well-being (50; 1).

Table 13 below outlines the distinguishing statements for Factor C.

Table 13. Distinguishing Statements for Expert Factor C (The Modelling Team)

Statement Number	Statement	Factor A Q-SV	Factor A Z-score	Factor B Q-SV	Factor B Z-score	Factor C Q-SV	Factor C Z-score
15	There need to be clear expectations about how people behave	-2	-0.73	4	1.28	5	2.14
27	This needs to be a safe environment	1	0.34	5	2.76	5	2.02
22	I try to be a pro-social role model	-1	-0.41	1	0.25	4	1.78*
40	I treat others fairly	0	-0.22	0	0.08	4	1.44*
36	I ask myself about the need to keep the public safe	-5	-2.49	1	0.45	3	1.23
47	I feel respected and valued	-2	-0.87	-3	-1.02	3	1.19*
11	We work together as a team	0	0.13	4	1.89	2	0.84
13	I try to be curious in why people behave in a certain way	4	1.55	-3	-1.15	2	0.66*
42	We take a non-judgemental approach	5	1.87	4	1.61	1	0.56*
50	I am thoughtful about how others feel	4	1.52	-1	-0.61	1	0.33*
9	We value everyone's ideas / thoughts	2	0.86	3	1.06	0	0.13
29	We accept that people make mistakes	2	0.89	-2	-0.96	0	0.03
12	Everyone has a voice	4	1.53	2	0.74	0	-0.3*
5	I am confident in how to support residents	-4	-1.3	1	0.4	-1	-0.4
38	Everyone should be included	2	0.84	2	0.74	-1	-0.41*
24	Residents are able to take care of each other	-4	-1.32	-5	-2.02	-1	-0.5
39	I need clear reasons for all decisions that are made	-5	-1.73	-5	-1.65	-2	-0.7*
46	We help each other to feel that they belong	3	0.93	1	0.24	-3	-1.06*
1	There needs to be a clear routine to the environment	-1	-0.32	3	1.13	-3	-1.13
26	All interactions with residents should be enabling	0	-0.13	3	0.81	-4	-1.49*
34	Not being condemning of others behaviour	3	0.98	-1	-0.68	-5	-1.59*
8	Residents can depend on each other	-2	-0.79	-4	-1.3	-5	-2.27*

Note: p<.05; * indicates significance at p < 0.01

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this Factor. For example;

> *"… clear expectations, these have to be clear to people about what you want them to do… explicit so that individuals understand that there are rules… I believe people need to take responsibility for themselves to develop a sense of responsibility and accountability for their own behaviour… The bottom line in general is if we want to*

treat people fairly, but we have to treat each other in a decent way, this is really important".

(Participant E5)

"Staff and residents need to have a sense of safety and security to allow people to get engaged in the process, to allow them to reflect… It needs to be a safe space to be able to think about individuals… it is about managing individuals within the whole environment… a team environmental approach versus a team methodology is much more about being practical within an environment. We don't want things to be too idealistic, we need to accept that there are differences in the way that people are, but things need to be consistent and safe".

(Participant E7)

"If we are safe and if we can protect the public then that is our mission statement. It is fundamental objectives in the AP… It is important to be curious… it is important to listen versus interpreting what other people are doing… it is important that we don't interpret everything all of the time to enable relationships to form naturally".

(Participant E12)

"there has to be the idea of modelling, the sense of direction and a sense of awareness of the environment and the therapeutic culture as a whole… we want them to be able to get on and make decisions from a safe place… the idea of an attachment to a safe base is really important, so that the residents can go and explore the world in a safer way".

(Participant E19)

5.4 Discussion of the Findings

The primary aim of Study One was to explore the viewpoints of what constitutes an ideal Enabling Environment as defined by participants who are regarded as being 'experts' in both Enabling Environments and in therapeutic environments / milieu. This is to gain a 'baseline', through this method of empirical inquiry, in understanding the qualitative narrative as to what Enabling Environments look like in their essence. This new understanding will hopefully contribute to the wider literature around the nature of Enabling Environments, and in this wider research project will then be used as a means to compare Q-Sorts across time within the participants within the approved premises in Study Two (Part B).

The analysis of the data identified three distinct and separate Factors that can be used to define an ideal Enabling Environment. Factor A was termed '*The Safe Relating Space*' and represents viewpoints that were more separate and independent than those reflected across the other two Factors. Essentially, this Factor offers an explanation of the meaningful relational process that comprise an Enabling Environment. It identifies that in such environments the intrinsic value is within the interpersonal connections, meaning in the relationships with each other within the environment, where there is a sense of inclusion and acceptance of each other where it is safe to share thoughts and emotions without judgement. The value in being curious about the needs of individuals and respecting ideas and contributions is aligned with the view that a meaningful Enabling Environment holds the nature and the quality of relationships between individuals as being recognised and highly valued (Johnson & Haigh, 2011) and where the quality of reciprocal social relationships enhances psychological growth, social learning and meaningful change (Haigh et al., 2012).

Furthermore, there is importance placed on creating a sense of a shared community or togetherness, individuals need to feel they have a voice to be able to contribute to the shared goals and to feel that they have influence on the goals and process of the social culture within the environment. These viewpoints are consistent with the notion of therapeutic alliance which is commonly understood to include respectful, open and trusting relationships (Hartley & Strupp, 1983), the experience of collaboration and support, recognition of shared goals and objectives and the experience of the others as understanding and empathic (Alexander & Luborsky, 1987; Foreman & Marmar, 1985). These notions are consistent with a core concept of a therapeutic community, i.e. where individuals are thought to be influential as participants and recipients of therapeutic processes with one another (Gill, 1967), and where the environment is suggested to be a living-learning situation and a culture of enquiry (Kennard, 2004; Main, 1989).

The process of fostering a genuine sense of belonging and being thoughtful about each other as is defined by this Factor reflects the focus on the quality of the interpersonal relationships as the means to effectively manage difficulties, and the network of these relationships is key to the psychological well-being of the individuals within that environment (Middelboe et al., 2001). Within this type of environment this is consistent with the principles of relational security, i.e. the knowledge and understanding we have of individuals and the emphasis being on effective relationships that are therapeutic and purposeful with understood limits (Appleby, 2010). Furthermore, this Factor also describes the notions of containment that is inherent within the concept of relational security, i.e. the process of understanding the difficult behaviours presented by residents and being able to understand and tolerate these so that the residents themselves can learn to understand how they are feeling and behaving by their reliance on the therapeutic relationship (Aiyegbusi, 2004b). The containing experience is found in the therapeutic relationship and by the clinician's ability to genuinely and authentically engage the person who is in distress. This is fundamental to the notion of effective relational security. These aspects are important given

the suggestions by Kurtz and Turner (2007) that in working with individuals with complex needs, a strong desire to have genuine and compassionate relationships is key; and that a socially empowered culture that fosters a compassionate and responsive therapeutic culture allows for a more psychologically based understanding of difficult behaviours (Turley et al., 2013).

One salient aspect that requires consideration in the interpretation of this Factor is the participant group. For example, this Factor does not include individuals actively working in approved premises, whereas Factors B and C both have participants that are in clinical practice within approved premises. It is suggested that the viewpoint of this Factor may represent a more idealised or conceptual perspective drawn from a position of thinking about such environments as opposed to experiences drawn from actively being in such environments. As individuals draw their frames of reference from their direct experiences (Hall & Lindzey, 1971), the fact that the participants in Factors B and C are active in their clinical practice within approved premises, the ethos of these two Factors may be more representative of '*function'* and '*process'* of Enabling Environments within such settings. This is important given approved premises are suggested to have two primary roles; "to help rehabilitate and resettle some of our most serious offenders, and to make sure that the public are protected in the offenders' early months in the community" (HMPI, 2017, P. 4).

Factor B is titled '*The Predictable System*' because the viewpoints of the participants are orientated towards the internal need for structure, routine, social and interpersonal boundaries, and the need for a team approach to create a safe interpersonal environment. This is as opposed to an environment where people feel safe to share their own internal experiences. This is consistent with the literature relating to the structure of social climate of therapeutic settings, for example that the need to support individuals practically, to help individuals solve their own problems, the need for an organised environment with rules and boundaries, with clarity of the rules and expectations of

the environment and how staff experience the need to impose controls and limitations are integral (Davies, 2004b; Moos & Houts, 1968; Schalast et al., 2008).

It is important to note that the participants defining this Factor are all clinicians actively working with an approved premise, and as such is suggested to be more defining of the reality of this type of therapeutic space. The perspectives identified within this Factor is consistent with the notion of procedural security, i.e. the structure of having policies and procedures, routine and organisation in order to allow for confidence in practice and ensure consistency (Reed, 1994; 1997). Essentially, it is suggested that the need for these structural procedures helps to create a sense of predictability and safety in an environment that is experienced as being complex and uncertain. This is relevant given that this Factor has emphasis on public protection and risk management. Having a unified team approach, consistent routines and structure is seen as the best systemic means of achieving predictability in this complex setting, and in working with individuals with complex needs in order to make sense of the environment and permit the environment to function.

Within this Factor, individual ideas and contributions are valued, resident should be given a voice, it is important to include others and that staff should make all interactions enabling coexists with a strong sense of teamwork and the view that residents should be dependent upon staff. This is Factor is suggested to reflect an orientation where an Enabling Environment is a process, enacted by the staff team rather than a relational or safe reflective space, and may represent the perspective that being reliant on relationships may be too uncertain or unpredictable and cannot contain the needs for feeling interpersonally safe in the physical space. This perspective lends support to the need for consistency (Turley et al., 2011) and the notion of containment (Haigh, 2013), in which individuals within a therapeutic culture need to be able to experience boundaries to what they can expect and hope to experience, and that these are set through the rules, structure and objectives of the particular environment. There is a shared perspective around the importance

of staff within the environment providing the structure and sense of direction within the social culture in order to provide a framework to work from, as opposed to there being the growth of more organic social and interpersonal networks. These perspectives are consistent with the literature suggesting that if working with individuals with complex needs is not well managed and if individuals are unsupported, there are established negative consequences to both psychological and emotional well-being (Elliot & Daley, 2012; Link et al., 2010; Scott, 2006).

Factor A reflects the value in the network of interpersonal relationships and Factor B represents the need for internal structures to attempt to achieve this. Following from this, Factor C is suggested to represent how a meaningful therapeutic milieu is operationalised within such an environment, and how the system supports or interfaces with the need for meaningful interpersonal relationships to manage risk. This Factor is termed '*The Modelling Team*' has many similarities with Factors A and B, and although it explains only a small percentage of the shared perspectives, the viewpoints are less focussed around defining the rules or expectations, or the focus on relating interpersonally and are directed towards how these are facilitated. The defining difference is that the viewpoints begin to reflect a team based pro-social modelling approach, thus thinking about the meaning of the relationships in the environment within the wider public, social and criminal justice frameworks.

The participants that define this Factor represent individuals that actively work in approved premises and who practice in other therapeutic environments. The viewpoints are consistent with Hurst et al. (2015) who suggested that balancing the therapeutic relationship with the notion of risk management was found to be a dilemma often faced by staff in forensic contexts, but something that is moderated by training, support and leadership. As in Factor B, there is a clear emphasis on staff providing the sense of direction, but in this Factor it is orientated towards pro-social modelling being used as a framework as opposed to structure, routine and boundaries. This is consistent with the suggestion that because a milieu within therapeutic environments is considered to be a

treatment modality, those involved in working within and delivering such environments have a role in the creation and maintenance of this milieu (Peplau, 1989).

This Factor defines an open awareness of the needs of the individuals within the environment, with resident's strengths and skills being considered, where they are valued more, greater support is offered, and where open interpersonal communication and feedback are valued. The concepts of fairness and creating a sense of a community is important. It is suggested that this is achieved through the demonstration of pro-social modelling and developing pro-social expectations by the team, particularly about how to represent or demonstrate meaningful socially and interpersonally appropriate relationships and responses to day to day issues. This concept is suggested to represent an important function of the Enabling Environment and is consistent with the literature identifying that it is necessary for such environments to have a structure in place to support engagement in pro-social activities and have a well-led staff team who understand the key principles of the regime, of the risk, needs of the residents and how the team need to be responsive to these needs in the environment (Cherry & Cheston, 2006; Latessa & Lowencamp, 2002).

Essentially, it is purported that what is thought to be needed to be created or modelled and represented in the Enabling Environment is what is desired to be internalised by those in the environment and required as a functional outcome, i.e. pro-social engagement with others. This Factor attempts to create the presence of a pro-social environment within the system that replicates the wider necessity of pro-social behaviour in the community. The notion of pro-social modelling is intrinsically related to the demonstration of relationships between individuals and the meaning placed on learning from these (Cherry, 2017), both individually but also within the wider context where the nature of the relationships between people is important to that environment. For example, Trotter (2009; 2010) outlines this concept as being related to the appropriate demonstration of collaborative problem-solving, modelling pro-social values and what constructs a

pro-social influence. This is suggested to be a key factor to what defines the Enabling Environment within an approved premise and it has been found to be important in managing risk related behaviour in forensic contexts (Listwan et al., 2006), integral in therapeutic alliance (Trotter, 2010) and a key skill in the supervision of offenders (Trotter, 2009).

In thinking about the Factors derived from the data holistically, the results highlighted three clear strands to understanding what might represent an ideal Enabling Environment. These are the principles of the *process*, the *function* and the strategy for the *desired outcome* of these environments. Factor A describes the importance of social networks and relationships as the food for the therapeutic process; Factor B defines the system and fabric by which this process can occur; and Factor C represents the function and the desired outcome of these environments. All of these three Factors are thought to be important and necessary and are suggested to represent the fertile soil for which an Enabling Environment can grow and develop. These elements are each suggested to be intrinsically related to and necessary for a functioning Enabling Environment and are indicative of this being a therapeutic environment and social milieu. We know that the therapeutic climate, the environment or the milieu are highly important within psychological and social therapeutic processes (e.g. Kelly & Welsh, 2016; Miller, 2011), and across these three Factors it is suggested that a balance is required between relational and procedural processes in order that a functional approach to achieve this can be achieved. For example, if the viewpoints in Factor A were too prominent there could perhaps be a lack of safety experienced because of the uncertainty and unpredictability in relying more on how people relate to each other, especially given it is a forensic setting. Whereas, if Factor B were too prominent this could result in a structure that is too rigid and dismissive of interpersonal relationships and lacking in a compassionate and understanding framework.

These three Factors derived from the Study parallel that which was historically suggested by Moos (1973), who conceptualised therapeutic environments as being an interrelated and overlapping relationship between organisational structure and climate, the social climate, the characteristics of individuals residing in such environments, and the means that change is reinforced or supported within such environments. These elements are suggested to be the backbone of an Enabling Environment, given the principle is to generate a climate or social 'space' to allow staff to be able to foster an interpersonal or 'relational' ethos, as well as an 'experiential' ethos, i.e. a reflective and socially and emotionally empowered culture that fosters a compassionate and responsive treatment or therapeutic culture. The collective subjectivity of the perspectives expressed across these three Factors are consistent with and incorporate the salient themes in the literature relating to therapeutic culture and milieu, and to the core principles of Enabling Environments. For example, the shared perspectives lend support to Townsend (2010), who suggested that there are five basic functions of an effective therapeutic milieu; a sense of containment, an experience of support, positive structure, an experience of involvement in the environment and the presence of validation of individuals and recognition of their psychological difficulties. Furthermore, across these three Factors the five core principles suggested to be the quintessence of a therapeutic environment (Haigh, 2013) are represented. These are (1) attachment, where the social concept of environment is the experience of the sense of belonging and relatedness to the environment and the community; (2) containment, where individuals are able to predictability experience boundaries through the rules, structure and objectives of the particular environment; (3) communication which is about openness and transparency in how individuals communicate with each other; (4) involvement and inclusion which relates to the shared experience of the community, being experienced as having others in mind and feeling held in mind by others in the social environment; and (5) agency which is an ethos of empowerment of the individual to develop social and interpersonal accountability and responsibility for both their thoughts and emotions, but also their social interactions and behaviour.

Chapter Six:
Study Two (Part A) – Time One (Approved Premise Staff Participants)

6. Results: Approved Premise Staff Participants Time One (Baseline)

6.1 Overview

This research uses Q-Methodology to explore the subjective viewpoints and shared perspectives of staff working within three approved premises at three separate timepoints across approximately an 18-month period as each approved premise works towards the transition into becoming an Enabling Environment. This chapter describes the analysis and interpretation of the data collected at Time One; Chapter 7 details the analysis and interpretation of the data at Time Two; and Chapter 8 details the analysis and interpretation of data at Time Three. Following this, Chapter 9 details the time series comparison of these three timepoints as well as the comparison with the 'prototype' developed for this study within Study One.

The aims of Study Two (Part A) are twofold. Firstly, to explore the meaning and significance of how the participants (i.e. staff working in the three approved premises) make sense of the approved premise environment before the Enabling Environment initiative commences. Secondly, through repeated Q-Sort Analyses, this study explores the experience of the staff participants in the approved premises as they are engaged in the process of becoming an Enabling Environment across time. Firstly, the data will be analysed and interpreted separately as independent Q-Sorts at each of the three timepoints. This will allow for a 'snapshot' or cross-sectional interpretation of how the participants experience the environment at each of the timepoints. Following this, and in Chapter 9, comparisons will be made within and across the analysis of the Q-Sorts at each of these three timepoints, and also compared to the 'Prototype' of an ideal Enabling Environment defined in Study One. This analysis in a time-series manner explores whether the participant's perspectives towards

this therapeutic environment and culture change over time with more actual, practical and social-environmental exposure to the Enabling Environment culture.

Chapter Four outlines how the data from each of the research participants at each of the three sites used in this particular Study was collected. To briefly recap, data from the participants at each of the three approved premises was collected at three consecutive timepoints where each participant employed at the approved premises at each time point completed an identical Q-Sort. Data from the participants at the three approved premises were combined for the analysis because of participant numbers. Table 14 below outlines the timepoints of the data collection at each of the three sites;

Table 14: Timepoints for Data Collection at Each Approved Premise.

	Time 1	**Time 2**	**Time 3**
MK	Sept-Oct 2017	July-Oct 2018	Feb-Mar 2019
GR	Oct-17	May-Jun 2018	Dec-18
ML	Jan-Feb 2018	June-Jul 2018	Dec 18-Jan 19

The process of the collation, analysis and interpretation of the data (i.e. the Q-Sorts) from each participant is detailed below and was replicated for each of the three timepoints in the data collection process. As defined previously, there are three basic processes of analysis in Q-Methodology. These are;

1. Moving from Q-Sorts to extracting raw Factors
2. Translating significant raw Factors that are extracted into Factor Arrays
3. Using the Factor Arrays to inform the qualitative interpretation of the Factors.

Moving through these basic phases was again undertaken using an abductive process to attempt to provide the best possible theoretical and psychological meaning to the data by defining each factor. This approach is believed to inherently be more rigorous and to preserve the integrity of the data, ensuring that the common viewpoints shared by the participants (Risdon et al., 2003) are explored, and to define as aspects of mutual coherence (Brouwer, 1999) in the data.

6.1.1 Software

KEN-Q Analysis (Banasick, 2018; 2019) was used to analyse the data from for all the Q-Sorts at each time point to identify the patterns and commonalities between the participants. As noted before, this software it was chosen because of being freely available from https://shawnbanasick.github.io/ken-q-analysis/, its compatibility with multiple computer platforms (i.e. PC and MAC) and a preferable user interface.

6.1.2 Data Entry

For the analysis of the data from each of the three timepoints, the relative placements of the 50 statements for each of the Q-Sorts at each time point were entered into separate Excel spreadsheets specifically designed for KEN-Q Analysis. This data entry process was double-checked, and finally these spreadsheets were inputted into KEN-Q Analysis and the analyses performed.

6.2 Q Analysis at Time One (Baseline)

6.2.1 Factor Extraction

Extracting factors from the Q-Sort is a process of reducing the data in a meaningful and interpretable manner to group the participants who share and express similar viewpoints. From the 14 participants in Time One, two factors were extracted and used for interpretation, therefore meaning that there were two distinct and meaningful patterns that the participants sorted their statements into.

Performing a Correlation Analysis is the first stage in factor extraction using KEN-Q Analysis, where the correlation matrix demonstrates the degree that each participant is similar or different to each other participant (Brown, 1980). The correlation matrix for the Time One Sorts (Appendix 14) demonstrates the relationships between the 14 Q-Sorts used in this time point.

A total of 14 Q-Sorts were inter-correlated and subject to a By-Person Factor Analysis using the dedicated computer package, KEN-Q Analysis. A Centroid Factor Analysis using Varimax Rotation was used to generate possible factor solutions. The rationale for this has been discussed in more detail in Chapter Four. Minor Manual Rotations were also attempted within the analysis to try to maximise the number of participants that significantly load on any one factor (+/- up to 90° in 10° increments), however any Manual Rotations that were undertaken did not increase the interpretability of the data.

Watts and Stenner (2012) suggest a starting point of extracting one factor for every six Q-Sorts in the study, and therefore because there were 14 participants in this analysis (N=14), analysis began by extracting a three-factor solution. Factor solutions for two to four Factors were computed for

thoroughness. Table 15 below provides a quantitative summary of the two, three and four factor solutions.

Table 15. Summary of the Different Possible Factor Solutions at Time One

Factor Solution	No. of Factors with Eigenvalue >1	No. of Factors meeting Humphrey's Rule	No. of Factors with Two significantly loading participants	Total No of participants accounted for in the solution	No. non-significant / confounding Participants	Amount of Variance Explained
Two	**2**	**2**	**2**	**11**	**3**	**34%**
Three	2	2	2	12	2	35%
Four	2	2	3	12	2	42%

When deciding on the best solution to most effectively represent the data, consideration in the analysis was given to the following six aspects;

g) The Kaiser-Guttman Criterion.

h) Humphrey's Rule.

i) The number of significantly loading Q-Sorts on each Factor.

j) The amount of variance explained by the solution.

k) Demographic information

l) Additional qualitative information obtained from the post Card Sort Interviews.

To recap, the process of a Factor Analysis is to reduce and simplify the data, so factors with Eigenvalues < 1 do not contribute to an effective reduction in the data. Taking each of these in turn; (a) The Kaiser-Guttman Criterion outlines that a Factor can be regarded as significant and as such meaningful if the Eigenvalue is > 1 (McKeown & Thomas, 1988). Regarding (b), Humphrey's Rule identifies a Factor as being significant if the cross product of the two highest Factor Loadings is

greater than 2x Standard Error (SE) (Watts & Stenner, 2012). SE is calculated by the following formula (Watts & Stenner, 2012);

SE = (1 ÷ √ Number of items in the Q-Set), or

SE = (1 ÷ √ 50) = 0.14.

Therefore, a Factor is found to meet the criteria for Humphrey's Rule and can be regarded as being a significant Factor if the cross product of the two highest Factor Loadings is greater than 0.28 (i.e. 2 x SE). A working example from the two highest Factor Loadings from Factor 1 (in Table 16 below) is as follows;

0.76 x 0.69 = 0.52,

0.52 > 0.28, therefore meets Humphrey's Rule.

As can be seen from Table 15 above, with the four and three-factor solutions, each of the analyses extracted only two factors with Eigenvalues > 1, and which met Humphrey's Rule. With the two-factor solution both of the two Factors extracted had significant Eigenvalues and met Humphrey's Rule.

Regarding (c), Watts and Stenner (2012) state that there must be a minimum of two participants who load significantly on each Factor to be able to meaningfully interpret that Factor. To calculate the value of the significantly loading Q-sorts, McKeown and Thomas (1998) outline that statistical significance at the $P < 0.01$ level is indicated by Factor Loadings that are 2.58 x greater than the SE, i.e. > ±0.36. As before, to calculate this the following formula was used;

SE = (1 ÷ √ Number of items in the Q-Set)

Therefore,

2.58 x (1 ÷ √ Number of items in the Q-Set), or

2.58 x (1 ÷ √ 50), or

2.58 x (0.14) = ± 0.36

As you can see from Table 2 above, the four-Factor solution had more than two participants significantly load (i.e. Factor Loading > ±0.36) on three of the four Factors, but one of these factors extracted met neither the Kaiser-Guttman Criterion nor Humphrey's Rule. The three-Factor solution resulted in only two Factors with more than two participants significantly loading and both of these factors met the Kaiser-Guttman Criterion and Humphrey's Rule. Finally, the two-Factor solution resulted in both Factors having more than two participants significantly loading and where both Factors met the Kaiser-Guttman Criterion and Humphrey's Rule.

Regarding (d), variance is understood as the degree to which the analysis has been more effective in identifying what meaning the Q-Sorts have in common. Watts and Stenner (2012) state that a total study variance of greater than 35% should be considered sound. From Table 15 above, the four and three-factor solutions explain the greatest amount of variance when compared to the two-factor solution, however the two-factor solution also explains a robust degree of variance in the data.

As in the previous analysis of the expert data, alongside the above considerations given to extracting Factors, the data was also qualitatively explored to try to determine which factor solution was more representative of the data. Through qualitatively reviewing the post Card Sort Interviews and considering the demographic information that the Factors were constructed from it was

decided that the two-factor solution was most representative of the data and allowed for a more thorough and informative account of the data.

In giving consideration to each of the six aspects outlined above, the four and three-factor solutions were not decided upon because both these solutions yielded only two usable Factors, and that through qualitative review were not thought to be most representative or best explained the data when compared to the two-factor solution. The two-factor solution yielded two usable Factors that each made an original contribution to understanding the data. Although the four and three-factor solutions explained marginally more variance, the analysis of the data from each of the solutions demonstrated the presence of only two usable Factors, and as such the two-factor solution provided a neater explanatory interpretation of the data.

The two-factor solution, yielding the two extractable and usable Factors was chosen because; (1) it prioritised the solution with robust explained variance, (2) it minimised the number of Factors that were extracted without any significant factor loadings, (3) each of the usable Factors met the Kaiser-Guttman Criterion and Humphrey's Rule, and (4) the data qualitatively best represented the data and each Factor extracted made an original contribution to understanding the data.

Therefore, with regard to the final factor solution, a two-factor solution was found to be most representative of the data, and as such two Factors were retained for the analysis. Together, these two Factors explained 34% of the variance. 11 of the 14 Q-Sorts loaded significantly over these two factors, i.e. with a loading of ±0.36 being significant at the $p < 0.01$ level. Two Q-Sorts were found to be non-significant and one was confounding.

Table 16 below demonstrates the factor loadings for the two Factors extracted. To ensure a clarity of reference to and between Factors (here, and at timepoints Two and Three), from this point

forward the Factors will be referred to as Factor 1.1 and 1.2 to represent Time One Factors 1 and 2. Factors yielded at Time Two will be defined as 2.1 and 2.2 etc.

Table 16. Rotated Factor Loadings for the Two Factors at Time One

Participant	Factor 1.1	Factor 1.2
A1	0.0358	**0.6486***
A2	0.1376	**0.3696***
A3	0.1037	0.3118
A4	0.354	-0.1803
A5	**0.5047***	0.118
B1	**0.5926***	0.3111
B2	-0.1264	**0.4567***
B3	**0.6947***	0.151
B4	0.0461	**0.3934***
B5	**0.6136***	-0.1512
C1	**0.7579***	0.2302
C2	**0.6247***	0.1078
C3	**0.5926***	0.2961
C4	0.4312	0.5939
Eigenvalue	**3.08**	**1.68**
Humphrey's Rule	**0.52**	**0.30**
Explained variance (%)	**22**	**12**

Note: (*) denotes the participants that loaded significantly on each Factor.

6.2.2 Factor Arrays

The final stage before the interpretation of the data is to define the factor arrays. Although each of the Q-Sorts that were not significant or were confounding were excluded from developing the factor array in this analysis, they were still considered in the interpretation of the factors to try to safeguard that nothing of value was lost from the data analysis.

All Q-Sorts (i.e. participants) that significantly load on the same factor are suggested to be those that share similar patterns in the way that they sort the statements. We can therefore say that each of the seven Q-Sorts exemplifying Factor 1.1 share a distinct and similar understanding of the subject matter. The factor exemplars are as such merged to form a single ideal Q-Sort for each Factor called a factor array. A factor array is calculated according to the procedure of weighted averages, i.e. higher loading exemplars (those with high factor loadings) are given more weight in the averaging process since they better exemplify the Factor. Because a factor array is a merged average of each of the Q-Sorts that significant load on that Factor it reflects a single complete Q-Sort.

Alongside the visual representation of the separate factor arrays for each Factor, Table 17 below demonstrates the relative rankings given to each statement within each Factor. Essentially, it shows how the participants, when their rankings were combined and averaged through the analysis, rank each of the statements on each Factor. The visual representations of the factor arrays for Factors 1 and 2 can be found in Appendix 15.1 and 15.2).

For example, Statement 14 “We can trust each other” was ranked at -4 on Factor 1.1 and +4 on Factor 1.2, thus beginning to tell us that a sense of experienced trust was not regarded as being very important to the viewpoints of the participants loading on Factor 1.1 but was much more central to the perspectives of those loading in Factor 1.2.

Table 17. Showing the Factor Arrays for Each of the Two Factors at Time One

	Statements	Factor 1.1	Factor 1.2
1	There needs to be a clear routine to the environment	2	-4
2	We must be genuine / authentic in how we treat others	2	1
3	I keep others welfare in my mind	3	-1
4	I need to feel supported to do my job	0	-5
5	I am confident in how to support residents	2	1
6	We have a genuine interest in each other	-4	0

7	I do not take things at face value	0	-3
8	Residents can depend on each other	-5	-5
9	We value everyone's ideas / thoughts	2	2
10	I am thoughtful about the resident's needs	1	0
11	We work together as a team	3	4
12	Everyone has a voice	1	1
13	I try to be curious in why people behave in a certain way	0	-1
14	We can trust each other	-4	4
15	There need to be clear expectations about how people behave	5	0
16	We should encourage residents to make their own choices	3	-1
17	Residents can depend on the staff to support them	1	2
18	We need to be open to give and receive feedback	0	5
19	We have shared goals about the culture between staff and residents	-3	2
20	I value the resident's contributions to the environment	-2	2
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	1	-2
22	I try to be a pro-social role model	2	4
23	I keep in mind the whole resident group, not just the individual	-1	0
24	Residents are able to take care of each other	-5	-2
25	I need strong leadership	-2	-3
26	All interactions with residents should be enabling	0	-1
27	This needs to be a safe environment	5	1
28	We take care of our environment	-2	-2
29	We accept that people make mistakes	-1	0
30	Residents can predictably get support when they need it	0	-2
31	We accept each other	-3	1
32	I look at the person not the problem	-1	-4
33	We relate to each other with a sense of consistency and predictability	1	2
34	Not being condemning of others behaviour	-2	0
35	I take responsibility for a sense of a community	-3	-1
36	I ask myself about the need to keep the public safe	4	3
37	I think about the resident's strengths and skills	-1	0
38	Everyone should be included	-1	5
39	I need clear reasons for all decisions that are made	-1	-2
40	I treat others fairly	3	-1
41	We allow everyone to have some autonomy	-2	0
42	We take a non-judgemental approach	0	3
43	There needs to be predictable consequences for people's actions	4	-4
44	I keep in mind 'can we manage this type of behaviour'	1	1
45	The boundaries between staff and resident relationships are clear	4	3
46	We help each other to feel that they belong	-3	1
47	I feel respected and valued	1	-3
48	I value supervision	-4	-3
49	Feeling safe to share our thoughts and emotions	-1	3
50	I am thoughtful about how others feel	0	-1

6.2.3 Relationships between the Factors

Table 18 below details the correlation scores (Pearson's r) between the two Factors derived from this analysis in Time one. The Q analysis revealed that there are two distinct and separate viewpoints described by the participants, with very little relationship between the two collective viewpoints expressed.

Table 18. Correlations Between Factor Scores at Time One

	Factor 1.1	Factor 1.2
Factor 1.1	1	
Factor 1.2	0.1998	1

6.3 Interpretation of the Factors at Time One

6.3.1 Overview

A narrative style (Watts & Stenner, 2012) was again used as this process helps to investigate the subtler nuances within the Factors to be identified and emphasised. As described above, because participants sort the statements according to the psychological significance they place on them (Stenner et al., 2008), it is assumed that every placement holds meaning and importance. Therefore, the interpretation of each of the factor arrays takes four elements into consideration; (1) the reflection of the entire item configuration; (2) incorporation of the distinguishing and consensus statements as they show which statements within each Factor array have been placed in a significantly different place to the other Factors, therefore demonstrating how the Factor is unique; (3) the demographics of the participants loading on each Factor; and (4) consideration to the qualitative comments provided by the participants who load on each of the Factors in order to

more holistically understand the reasoning behind the sorting process. A 'Crib Sheet' approach (Watts & Stenner, 2012) was again used to assist in the interpretation of the Factors (Appendix 16.1 and 16.2). The Consensus Statements from the analysis at Time One can be found in Appendix 16.3.

6.3.2 Factor 1.1: The Predictable Environment

Factor 1 has an Eigenvalue of 3.08 and explains 22% of the study variance. Seven participants are significantly loaded on this Factor with one Manager, four Offender Supervisors and two Residential Assistants. One participant was from MK approved premise, three from GR and three from ML. Four of these are male, three are female; the mean age of the participants is 44 years; and the average time working within approved premises is 82.6 months.

The essence of this factor surrounds a focus on how the staff team predictably manage problematic behaviours and create an environment that is safe from physical threat for staff and residents within the approved premise in order to uphold public protection. This is established through the team setting up and implementing staff-directed procedure, rules, structure and consequences.

The main narrative underpinning this Factor surrounds there needing to be an environment where individuals are safe from physical threat from each other (27; 5) and where there is limited importance placed on creating a sense of emotional or interpersonal safety to be able to share thoughts and emotions with each other (49; 0). Public protection is also a core defining element of this Factor (36; 4) upheld through clearly prescribed expectations about how residents behave socially and interpersonally (15; 5). Similarly, these expectations exist within a system where working together as an effective staff team (11; 3) with overt social and interpersonal boundaries and a routine (45; 4, 1; 2) that allows the team to provide consistency in their approach to deliver

predictable consequences for negative behaviours (43; 4) demonstrated by the residents within the approved premise.

Regarding the interpersonal culture of the approved premise as defined by this Factor, the participants express that there is limited trust offered by staff towards the residents (14; -4), and a strong view that residents are not thought to be able to take care of each other or trusted to be able to depend on each other for mutual support (24; -5, 8; -5). What is also evident is that there is minimal collaboration or alliance experienced between staff and residents as goals about the culture of the environment in the approved premise are not shared between staff and residents (19; -3). Similarly, staff express that they take little responsibility for a implementing a sense of community (35; -3), there is limited emphasis in supporting residents to feel that they belong within the social environment (46; -3) or towards including and involving others within the social processes or decision making (38; -1). There is also not a clear emphasis on staff being able to provide the residents with support when they need it (30; 0).

With regard to managing interpersonal behaviours within the approved premise, there is little value actually placed on resident's contributions to the environment (20; -2) and staff are lacking in their openness to provide and receive feedback (18; -1). This is further exemplified by staff expressing that they have a limited genuine interest in others (6; -4), that they often struggle to be openly accepting of the residents (31; -3) and can take a judgmental and condemning approach to the resident's behaviours (42; 0, 34; -2). Furthermore, staff tend to be inconsiderate of resident's strengths and skills (37; -1), there tends to be a focus on problems rather than on understanding the resident's behaviours (32; -1) and a limited recognition that the residents can make genuine mistakes (29; -1).

Notwithstanding, there is an underlying expression of a duty of care to the residents as staff have voiced that it is important to hold in mind the general well-being and welfare of residents (3; 3), that they treat residents fairly and offer parity (40; 3), and that residents themselves are encouraged to make their own choices in how to act (16; 2) and in thinking about the social and emotional impact of difficult behaviours on the wider resident group (21; 1).

Table 19 below outlines the distinguishing statements for Factor 1.1.

Table 19. Distinguishing Statements for Factor 1.1 (The Predictable Environment)

Statement Number	Statement	Factor 1.1 Q-SV	Factor 1.1 Z-score	Factor 1.2 Q-SV	Factor 1.2 Z-score
27	This needs to be a safe environment	5	2.51*	1	0.401
15	There need to be clear expectations about how people behave	5	2.1*	0	0.28
43	There needs to be predictable consequences for people's actions	4	1.62*	-4	-1.496
40	I treat others fairly	3	1.31*	-1	-0.292
3	I keep others welfare in my mind	3	0.66*	-1	-0.236
16	We should encourage residents to make their own choices	3	0.61*	-1	-0.405
1	There needs to be a clear routine to the environment	2	0.58*	-4	-1.362
22	I try to be a pro-social role model	2	0.58*	4	1.634
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	1	0.48*	-2	-0.76
47	I feel respected and valued	1	0.22*	-3	-1.221
4	I need to feel supported to do my job	0	0.14*	-5	-2.071
42	We take a non-judgemental approach	0	0.07*	3	0.873
7	I do not take things at face value	0	0.03*	-3	-1.047
18	We need to be open to give and receive feedback	0	0.02*	5	1.646
30	Residents can predictably get support when they need it	0	0.02*	-2	-0.98
32	I look at the person not the problem	-1	-0.11*	-4	-1.795
39	I need clear reasons for all decisions that are made	-1	-0.15	-2	-0.765
49	Feeling safe to share our thoughts and emotions	-1	-0.19*	3	1.157
38	Everyone should be included	-1	-0.39*	5	1.827
34	Not being condemning of others behaviour	-2	-0.79	0	-0.093
20	I value the resident's contributions to the environment	-2	-0.85*	2	0.866
31	We accept each other	-3	-0.91*	1	0.515
19	We have shared goals about the culture between staff and residents	-3	-0.92*	2	0.841

46	We help each other to feel that they belong	-3	-1.01*	1	0.579
14	We can trust each other	-4	-1.29*	4	1.375
6	We have a genuine interest in each other	-4	-1.66*	0	0.153
24	Residents are able to take care of each other	-5	-2.42*	-2	-0.807

Note: p < 0.05; * indicates significance at p < 0.01

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this factor. For example;

> *"It's important to have predictable consequences and boundaries, because if we don't things won't work really. Things need to be consistent. Also, routine is important as things can get chaotic. People, residents, they need to know what is expected of them".*

> *"I can say that I have no idea of how a shared culture feels. This is the first day of the process, so we need to get to grips with that process".*

(Participant A5)

> *"We are not here to be their friend. Safeguard is an important role here. Residents and staff have to feel safe, there has to be rules … We need to have boundaries to do the job that we do. Residents need to know where they stand, there needs to be clear expectations, so if I need to talk to an individual about his risk then this is clear and this is safe… I know an enabling environment should be including everyone, but some decisions residents cannot be involved in… the biggest concern for me in this approved premise is the concern about how we manage and balance risk and responsibility".*

(Participant B5)

"I need others to subscribe to what I want people to do therefore we have to work together so things are not undone… It is always a balance of what should and what ought to be done, first is what is practical in the environment… we want them to trust us rather than each other so we can support and help them… We need to be safe, they need to feel safe to create an environment, to be able to talk and to share.".

(Participant B1)

"In regard to it being a safe environment if it is not safe then things do not keep people safe and people do not feel safe and we do not keep the public safe. Keeping the public safe is our number one role. We work within a public protection framework… In regard to trusting each other I do not trust residents, that's it. The nature of their offending means that you cannot really trust them. I do hope that they will become law abiding and more law abiding individuals".

(Participant B3)

"You have to have a security head in this environment, we are dealing with difficult people and we need to feel safe and if something did happen to feel supported. It is not about the emotional threat, I need to know others will support me if I need them to as there are unpredictable characters here in the AP".

(Participant C2)

"About feeling safety, if the environment is not safe then we can't go forward. There needs to be clear expectations about how people behave, a sense of rules and structure… People make mistakes, how long do we accept mistakes, there needs to

be clear expectations. If they keep making them and doing them intentionally and not seeking help then we need to think about this in a different way".

(Participant C3)

6.3.3 Factor 1.2: Inclusion and Acceptance

Factor 2 has an Eigenvalue of 1.68 and explains 12% of the study variance. Four participants are significantly loaded on this factor with one Manager, two Offender Supervisors and one Residential Assistant. Two participants were from MK approved premise and two from GR. Three are male, one is female; the mean age of the participants is 52.3 years; and the average time working within approved premises is 108.3 months.

This Factor relates to the aspiration of the staff team to predictably manage problematic behaviours within the approved premise and to create an emotionally safe environment where residents are more able to share their thoughts and emotions with each other. This is sought through pro-social modelling and developing a social environment where the residents are included and involved in the fabric of the social processes and decision making.

The staff viewpoints expressed in this Factor relate to the importance in creating an emotionally safe environment where residents are more able to share their thoughts and emotions with each other (49; 3), whilst also being aware of the need to maintain an environment where individuals are safe from physical threat from each other a (27; 1).

This Factor is defined by the aspiration of the staff to create a social culture that is underpinned by the staff team engaging with and demonstrating to the residents what constitutes appropriate and

pro-social communication and behaviour (22; 4). There is significant value placed on including and involving the residents within the social processes and decision making (38; 5), where the staff are open and accepting to be able to give and receive feedback with residents (18; 5), and where a non-judgemental approach to engaging with and understanding others is sought (42; 3). Resident's Ideas are often valued as are their contributions to the environment (9; 2, 20; 2), and there is an essence of helping the residents to feel that they belong within the approved premise (46; 1).

However, it is expressed that residents are not thought to be able to take care of each other or trusted to be able to depend on each other for mutual support within the approved premise (8; -5, 24; -2). Residents are also not always encouraged to make their own choices (16; -1) but staff expressed a perspective that residents can depend upon staff to support them (17; 2).

Public protection and a focus on public safety is also a key element of this Factor (36; 3) supported by there being a solid sense of coherence in working as an effective team (11; 4) where individuals trust one another (14; 4). There is also a sense of confidence held about this position because staff expressed that they do not need to feel supported or respected to undertake their roles (4; -5, 47; -3), they did not need strong leadership (25; -3) to maintain this position, and that they do not always need clear reasoning for decisions that are made (39; -2).

The staff identified that they hold clear social and interpersonal boundaries between themselves and the residents (45; 3), and although there is some limited focus on the need for clearly prescribed expectations about how residents behave socially and interpersonally (15; 0) there is no reliance on the provision of clear structures or routines in the environment or the need to deliver predictable consequences for negative behaviours (1; -4, 43; -4).

What is also evident is that there is a clearer experience of collaboration and alliance experienced between the staff and the residents as goals about the culture of the environment in the approved premise can be shared between staff and residents (19; 2).

Notwithstanding, there is also a sense of pragmatism expressed by the staff in running the approved premise as residents are not always able to get support when they need it (30; -2), it is not always possible to prioritise the welfare resident's require (3; -1), and being able to engage with the residents with fairness and parity does not always take precedence (40; -1). What is also salient and expressed as being more pertinent in the staff viewpoints in this Factor is that there tends to be a focus on dealing with problems and managing problematic behaviours in the environment rather than understanding why people behave in a certain way (32; -4, 7; -3, 13; -1) or in thinking about the impacts on the wider residents group (21; -2).

Table 20 below outlines the distinguishing statements for Factor 1.2.

Table 20. Distinguishing Statements for Factor 1.2 (Inclusion and Acceptance)

Statement Number	Statement	Factor 1.1 Q-SV	Factor 1.1 Z-score	Factor 1.2 Q-SV	Factor 1.2 Z-score
38	Everyone should be included	-1	-0.39	5	1.83*
18	We need to be open to give and receive feedback	0	0.02	5	1.65*
22	I try to be a pro-social role model	2	0.58	4	1.63*
14	We can trust each other	-4	-1.29	4	1.38*
49	Feeling safe to share our thoughts and emotions	-1	-0.19	3	1.16*
20	I value the resident's contributions to the environment	-2	-0.85	2	0.87*
42	We take a non-judgemental approach	0	0.07	3	0.87*
19	We have shared goals about the culture between staff and residents	-3	-0.92	2	0.84*
46	We help each other to feel that they belong	-3	-1.01	1	0.58*
31	We accept each other	-3	-0.91	1	0.52*
27	This needs to be a safe environment	5	2.51	1	0.4*
15	There need to be clear expectations about how people behave	5	2.1	0	0.28*
6	We have a genuine interest in each other	-4	-1.66	0	0.15*
34	Not being condemning of others behaviour	-2	-0.79	0	-0.09
3	I keep others welfare in my mind	3	0.66	-1	-0.24*
40	I treat others fairly	3	1.31	-1	-0.29*
16	We should encourage residents to make their own choices	3	0.61	-1	-0.41*
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	1	0.48	-2	-0.76*
39	I need clear reasons for all decisions that are made	-1	-0.15	-2	-0.77
24	Residents are able to take care of each other	-5	-2.42	-2	-0.81*
30	Residents can predictably get support when they need it	0	0.02	-2	-0.98*
7	I do not take things at face value	0	0.03	-3	-1.05*
47	I feel respected and valued	1	0.22	-3	-1.22*
1	There needs to be a clear routine to the environment	2	0.58	-4	-1.36*
43	There needs to be predictable consequences for people's actions	4	1.62	-4	-1.5*
32	I look at the person not the problem	-1	-0.11	-4	-1.8*
4	I need to feel supported to do my job	0	0.14	-5	-2.07*

Note: $p < 0.05$; * indicates significance at $p < 0.01$

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this factor. For example;

"… we need to be able to trust each other, we need there to be a clear air of trust… I don't need to feel supported to do my job, I have the confidence and I can do the work… taking care of each other is not essential, but people can be happier".

(Participant A1)

"… we can trust each other, and we can work together as a team are important… you need both of these for the place to run effectively. We need to be able to rely on colleagues and we need to be able to support each other in this environment… I don't need routine, I am not a believer in this. I deal with things as they come along… I am an individual and I expect others to be individuals".

(Participant A2)

"… most important statements are everyone should be included, and everyone has a voice. From the team and the residents to the environment if I don't feel valued and included then I don't feel valued. If my opinion is not valued then people are not prepared to be involved".

"There needs to be a clear routine, this needs to be adaptable to the person or else this is difficult, as there are many different routines… I look at the person not the problem… there has to be a reason why someone behaves. We have to tackle that behaviour not the person. Understanding the problem to make them more able to change themselves and give them the tools to be able to change is what we are trying to do. We are trying to get people to make the choices themselves".

"There is also a conflict of what we ought to do, a balance between empowerment and support versus public protection. We try not to make the environment feel

hierarchical… however we have to pay attention to the negative characteristics or traits of individuals, and it is important to make sure residents are heard but not over any other residents".

(Participant B2)

"… I think enabling environment is a good idea, but I think we as a team need to understand what it is and the differences… need to make sure that we are not undermining what we do as a team in terms of public protection…My job is to run a hostel to make more positive experiences of staff and residents and not for them to linger here and malinger. I would like to make the environment as pleasant as possible and as enabling as possible, but if I have to kick someone out, as I have 8 more waiting to come through the door I have to think about risk versus supporting the residents".

(Participant B4)

6.4 Discussion of the Findings

One of the first steps in trying to influence culture to be more rehabilitative is to understand the current culture of an establishment (Tew, 2017). Therefore, the aim of this first aspect of Study Two (Part A), i.e. the analysis of Time One is to explore the meaning of how the participants make sense of the approved premise culture before the Enabling Environment initiative commenced. The analyses of time Two and Three, and the comparison with the Expert Participants is to then explore the experience of the participants on two further occasions as they are engaged in the process of becoming an Enabling Environment.

The analysis revealed two distinct and separate viewpoints evident at Time One (Factors 1.1 and 1.2), and together these comprise the collective interpretation of what the participants understand to be important within their environments. Factor 1.1 represents the majority of the viewpoints of the staff in the study at this time point, and as such reflects a more defining description of how the environments are viewed and experienced by the staff.

Factor 1.1 was termed '*The Predictable Environment*' as it reflects the necessity to have an environment safe from physical threat where this safety is derived from staff-imposed routine, clear expectations, boundaries and predictable consequences for behaviours. This exists within a clear public protection and risk management agenda. This links to research literature suggesting that consistency is important in the approach to managing individuals with complex needs (Turley et al., 2011) and with the objective of approved premises being to reduce the risk of further offending by both supervision and meaningfully engaging people, but within a monitoring and surveillance framework (Cherry & Cheston, 2006).

A core element of this Factor is defined by the absence of the willingness to trust residents within this environment, and where the sense of safety is achieved through the structure and framework of expectations placed on others, as opposed to being gained from an experience of relating socially or interpersonally with each other. Markham and Trower (2003) suggested that the effective care and treatment of individuals with complex psychological needs relies upon factors inherent in the treating team, the environment and the organisation as a whole. In this Factor, it is evident that it is safer and more consistent to impose expectations and rules that have consequences when breached than to build meaningful relationships with residents to understand their emotional experiences and understand risk. An experienced sense of safety is regarded as being central to working with individuals with complex needs (Bos et al., 2012) and this is described in this Factor

through procedural security (Reed, 1994), which within a supportive staff team has been found to be protective factors for understanding the risk of violence (Allen & Beech, 2010; Appleby, 2010).

Within this Factor relationships are defined by being prescriptive of how others should behave as opposed to modelling how to relate healthily to others. As such, there is a top-down approach to communication, there is little sense of shared community or placing value in the notion of belonging to the collective group of residents. This does not necessarily mean that the staff team fail to demonstrate care and support of the residents or that they lack interest in or are fundamentally unaccepting of the residents (as is in fact evidenced by care for their welfare and the viewpoints in Factor 1.2), moreover it reflects a systemic approach used to achieving the sense of safety that is held as paramount. This therefore means that there is much less need to focus on individual meanings and idiosyncrasies in the resident's behaviours or in creating a cohesive community based upon relationships. This is consistent with the concept of containment (Haigh, 2013 Martin & Street 2003), which relates to the need for predictability and dependability in how people experience boundaries through the rules, structure and the objectives of an environment.

What is also present in this Factor and represents a more supportive position is that staff describe an importance in treating residents fairly and safeguarding their well-being and welfare. Within this context this is suggested to be centred around the interpersonal and practical needs and not their emotional needs. There is a position of relating to the residents genuinely and with authenticity in having their safety in mind, but without accepting, trusting or having genuine interest in them as individuals. This has links to literature that suggests that an environment characterised by guardedness and suspicion of others will limit how individuals express their vulnerable thoughts and emotions (Ward et al., 2003) and affect change. This is exemplified by the viewpoint that residents within the approved premises are encouraged to make their own choices but without trust in allowing them to demonstrate autonomy in their decision making. This is suggested to

derive from a position where the overarching public protection framework restricts the possibilities of decision making because of the rules imposed. What is important to note is that social support as identified here in this Factor is regarded as the key to motivation to change and has been found to be indispensable in psychosocial interventions such as an Enabling Environment (Beutler et al., 2000).

Factor 1.2, although a less prevalent set of shared viewpoints identifies a clear existence within the approved premise of a desire to create an emotionally safe environment. This Factor was termed *'Inclusion and Acceptance'* and is defined by viewpoints orientated towards meaningfully relating to each other, open collaboration and feedback between staff and residents, the acceptance and inclusion of each other and shared goals between staff and residents and staff. This is consistent with the view that relationships are regarded as being important to an Enabling Environment and are integral in social learning and psychological change (Haigh et al., 2012). Although a focus on public protection and risk management remains, the prevailing elements are around creating a culture within the environment where it is safe for residents to relate to each other to share their thoughts and emotions above the need for interpersonal safety or security.

The glue that holds this Factor together is in creating an atmosphere where trusting connections are made possible through fostering a shared sense of belonging and community culture. It is suggested that as defined by this Factor, these social processes are developed and maintained through the confident sense of teamwork and through pro-social communication and relationships, modelled by staff to residents. This is consistent with the principles of communication identified by Haigh (2013) which relates to sharing, offering feedback and being open to challenge, as well as of acceptance and being non-judgemental. Within this Factor there is a sense of transparency in how individuals communicate with each other, thus promoting individuals to rely upon social relationships to address their individual needs and difficulties.

It is understood that for pro-social modelling to be effective, there needs consistent communication about expectations, boundaries and appropriate behaviour, and there needing to be a shared understanding by the team of attitudes and behaviours being modelled to the residents (Cherry & Cheston, 2006). This is present within the viewpoints of this Factor, and unlike Factor 1.1, where relating to residents was through consequences and the requirement for expectations, this Factor incorporates relating to others in a socially supportive manner where the staff are clear in their social and interpersonal boundaries. The presence of these aspects are also consistent with the principles of attachment and involvement / inclusion within therapeutic environments as defined by Haigh (2013). Haigh's notion of attachment relates to the importance of a sense of belonging and social connection to others within the environment and to a shared community. This is further cemented by these individual's experience of involvement and inclusion, which is related to the experience of both holding others in mind and being thought about in a shared sense of community as a contributing member of that social environment. This is suggested to foster interdependence, trust and a sense of agency through the experience of the meaningful relationships with each other (Haigh, 2013) which was also found to be present in this Factor.

Within this Factor there is a sense of conflict expressed by the staff between the value placed on creating a sense of safety to explore relationships and the emotions therein, and not always being able to be predictably available or being able to fully explore the function behind why people act. This is important given that a therapeutic milieu is considered to be a treatment modality and that, in complex environments such as this, a model needs to be in place for staff to work from as they have a role in the creation and maintenance of this milieu (Peplau, 1989). There is however pragmatism expressed by the participants balancing the complex needs of the residents living in the approved premises and the demands on resources and expectations, including from the wider criminal justice system. This is aligned with the 'living-learning principle' (Jones, 1968) suggesting that people's experience of being a contributing part of a social environment promotes

membership to that culture and is achieved through the experience of the relationships with each other.

Across both Factors there is a consensus that there has to be both physical safety and the experience of feeling safe from emotional threat for individuals to share their thoughts and emotions to be able to safely relate to each other. There is an emerging balance between the need for procedural security and in developing relational security (Appleby, 2010; Reed, 1994) and the importance and value placed in the interpersonal relationships and their meaning to manage risk. What is evident in the research in working with complex individuals with forensic needs is that both procedural and relational security are integral to the safe and effective functioning of such environments especially where there are therapeutic goals (Kennedy, 2002; NHS, 2014; Reed, 1997); and staff working in forensic settings must accomplish a balance between custodial and relational expectations (Hammer, 2000; Martin & Street, 2003). Furthermore, this study suggests that with such an overt public protection framework (i.e. the approved premises being a National Probation Service environment) approved premises need to have a framework to manage behavioural predictability through structure and clear consequences (Factor 1.1), i.e. procedural security in order to safely, and with confidence, create the presence of meaningful and constructive therapeutic relationships with the residents, i.e. relational security (Factor 1.2). This supports the guidance suggested by Appleby (2010) in that "safe and effective relationships between staff and service users need to be professional, therapeutic and purposeful. Limits enable staff to maintain their professional integrity and say 'no' when boundaries are being tested" (p. 5).

Chapter Seven:
Study Two (Part A) - Time Two (Approved Premise Staff Participants)

7. Results: Approved Premise Staff Time Two

7.1 Overview

The data entry processes and the software that was used remained the same within this process of analysis as was used in Chapter Six. The timepoints at which the data was collected is also detailed in Chapter Six.

7.2 Q Analysis at Time Two

7.2.1 Factor Extraction

From the 18 participants at Time Two, two Factors were extracted and used for interpretation, therefore meaning that there were two distinct and meaningful patterns that the participants sorted their statements into.

A Correlation Analysis is the first stage in factor extraction using KEN-Q Analysis. This can be found in Appendix 17.

KEN-Q Analysis was used to subject the 18 Q-Sorts to the By-Person Factor Analysis. A Centroid Factor Analysis using Varimax Rotation was again used to generate possible factor solutions to focus the analysis on the commonality of the data (Watts & Stenner, 2005). As before, minor Manual Rotations were also attempted within the analysis to try to maximise the number of participants

that significantly load on any one factor (+/- up to 90° in 10° increments), however any Manual Rotations that were undertaken did not increase the interpretability of the data.

Within the analysis of the time Two Q-Sorts analysis began by extracting a four-factor solution, and subsequently factor solutions for two to four Factors were computed for thoroughness. Table 21 below provides a quantitative summary of the two, three and four factor solutions.

Table 21. Summary of the Different Possible Factor Solutions at Time Two

Factor Solution	No. of Factors with Eigenvalue >1	No. of Factors meeting Humphrey's Rule	No. of Factors with Two significantly loading participants	Total No of participants accounted for in the solution	No. non-significant / confounding Participants	Amount of Variance Explained
Two	**2**	**2**	**2**	**16**	**3**	**34%**
Three	2	3	3	14	4	39%
Four	2	3	3	15	4	40%

Taking each of these in turn, Table 21 above details that each of the Factor solutions result in only two Factors meeting the Kaiser-Guttman Criterion (i.e. EV > 1). Regarding Humphrey's Rule (HR > 0.28), the three and four-Factor solutions resulted in three Factors that met this criterion. The two Factors extracted in the two-Factor solution both met Humphrey's Rule and the Kaiser-Guttman Criterion.

Regarding a minimum of two participants needed to load significantly on each Factor to be able to meaningfully interpret that Factor (Watts & Stenner, 2012), statistical significance was again calculated at the $P < 0.01$ level as being ±0.36. As you can see from Table 21 above, the four-factor solution had more than two participants significantly load on three of the four Factors, but two of these Factors extracted did not meet the Kaiser-Guttman Criterion.

The three-factor solution, although it resulted in each of the three Factors having more than two participants significantly loading, one of these Factors extracted did not meet the required Kaiser-Guttman Criterion.

Finally, the two-factor solution resulted in both Factors having more than two participants significantly loading and where both Factors met the Kaiser-Guttman Criterion and Humphrey's Rule.

Regarding explained variance, it can be seen that the four and three-factor solutions explain the greatest amount of variance when compared to the two-factor solution, however the two-factor solution also explains a robust degree of variance in the data.

The data was also qualitatively explored to try to determine which factor solution was more representative of the data. Through this process of reviewing the Post Card Sort Interviews and considering the demographic information that the Factors were constructed, it was evident that the two-factor solution was most representative of the data and allowed for a more thorough and informative account of the data.

In giving consideration to each of the six aspects outlined above, the two-factor solution, yielding the two extractable and usable Factors was chosen because; (1) it prioritised the solution with robust explained variance, (2) it minimised the number of Factors that were extracted without any significant factor loadings, (3) each of the usable Factors met the Kaiser-Guttman Criterion and Humphrey's Rule, and (4) the data qualitatively best represented the data and each Factor extracted made an original contribution to understanding the data.

Therefore, with regard to the final factor solution, a two-factor solution was found to be most representative of the data, and as such two Factors were retained for the analysis. Together, these two Factors explained 34% of the variance. 16 of the 18 Q-Sorts loaded significantly over these two factors, i.e. with a loading of ±0.36 being significant at the $p < 0.01$ level. One Q-Sort was found to be non-significant and one was confounding.

Table 22 below demonstrates the factor loadings for the two Factors extracted.

Table 22. Rotated Factor Loadings for both Factors at Time Two

Q sort	Factor 2.1	Factor 2.2
A2	**0.3861***	0.1828
A4	**0.386***	0.0852
A5	**0.6061***	0.2243
A6	**0.5461***	0.3538
A7	0.2931	0.3202
A8	**0.4996***	0.3132
A9	-0.0924	**0.643***
B1	**0.4084***	0.3286
B2	**0.4533***	0.0176
B4	**0.5089***	0.0577
B5	0.3527	**0.3915***
B6	**0.4497***	-0.1848
B7	**0.408***	0.0508
C1	0.4773	0.5271
C2	0.0818	**0.7638***
C3	0.1767	**0.7567***
C4	**0.6928***	0.2873
C5	0.1188	**0.4995***
Eigenvalue	**3.24**	**2.88**
Humphrey's Rule	**0.42**	**0.58**
Explained variance (%)	**18**	**16**

Note: (*) denotes the participants that loaded significantly on each Factor.

7.2.2 Factor Arrays

A factor array is a merged average of each of the Q-Sorts that significantly load on that Factor and as such reflects a single complete Q-Sort. Table 23 below demonstrates the relative rankings given to each statement within each Factor. The visual representations of the factor arrays for Factor 2.1 and 2.2 can be found in Appendix 18.1 and 18.2).

Table 23. Showing the Factor Arrays for Each of the Two Factors at Time Two

	Statements	Factor 2.1	Factor 2.2
1	There needs to be a clear routine to the environment	1	2
2	We must be genuine / authentic in how we treat others	1	-2
3	I keep others welfare in my mind	3	2
4	I need to feel supported to do my job	-3	1
5	I am confident in how to support residents	4	-1
6	We have a genuine interest in each other	-4	0
7	I do not take things at face value	-2	-4
8	Residents can depend on each other	-5	-5
9	We value everyone's ideas / thoughts	0	-1
10	I am thoughtful about the resident's needs	4	1
11	We work together as a team	4	3
12	Everyone has a voice	2	0
13	I try to be curious in why people behave in a certain way	-2	0
14	We can trust each other	0	1
15	There need to be clear expectations about how people behave	0	5
16	We should encourage residents to make their own choices	0	-2
17	Residents can depend on the staff to support them	5	3
18	We need to be open to give and receive feedback	-1	1
19	We have shared goals about the culture between staff and residents	0	-2
20	I value the resident's contributions to the environment	2	-3
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	3
22	I try to be a pro-social role model	-1	0
23	I keep in mind the whole resident group, not just the individual	1	-3
24	Residents are able to take care of each other	-5	-5
25	I need strong leadership	-4	2
26	All interactions with residents should be enabling	3	-1
27	This needs to be a safe environment	5	4
28	We take care of our environment	1	-2
29	We accept that people make mistakes	-1	-4
30	Residents can predictably get support when they need it	1	0
31	We accept each other	0	-4
32	I look at the person not the problem	-1	1
33	We relate to each other with a sense of consistency and predictability	-2	-1

34	Not being condemning of others behaviour	-2	-2
35	I take responsibility for a sense of a community	-3	-1
36	I ask myself about the need to keep the public safe	3	4
37	I think about the resident's strengths and skills	2	-3
38	Everyone should be included	2	-1
39	I need clear reasons for all decisions that are made	-3	2
40	I treat others fairly	3	2
41	We allow everyone to have some autonomy	-4	-3
42	We take a non-judgemental approach	0	1
43	There needs to be predictable consequences for people's actions	-1	5
44	I keep in mind 'can we manage this type of behaviour'	-1	3
45	The boundaries between staff and resident relationships are clear	2	4
46	We help each other to feel that they belong	1	-1
47	I feel respected and valued	-2	1
48	I value supervision	-3	0
49	Feeling safe to share our thoughts and emotions	-1	0
50	I am thoughtful about how others feel	1	0

7.2.3 Relationship between the Factors

Table 24 below details the correlation scores between the two Factors derived from this analysis in Time Two. The Q analysis revealed that there are two distinct and separate viewpoints described by the participants, with some, although limited relationship between the two collective viewpoints expressed.

Table 24. Correlations Between Factor Scores at Time Two

	Factor 2.1	**Factor 2.2**
Factor 2.1	1	
Factor 2.2	0.3944	1

7.3 Interpretation of the Factors at Time Two

7.3.1 Overview

To globally understand the reasoning behind the sorting process, a narrative style (Watts & Stenner, 2012) was again used taking into account entire item configuration; the distinguishing and consensus statements; the demographics of the participants; and the qualitative comments provided by the participants. A 'Crib Sheet' approach (Watts & Stenner, 2012) was again used to assist in the interpretation of the Factors (Appendix 19.1 and 19.2). The Consensus Statements can also be found at Appendix 19.3.

7.3.2 Factor 2.1: The Providing Team

Factor 1 has an Eigenvalue of 3.24 and explains 18% of the study variance. 11 participants are significantly loaded on this factor with two Managers, four Offender Supervisors and five Residential Assistants. Seven of these are male, four are female; five participants were from MK approved premise, five were from GR and one was from ML; the mean age of the participants is 43.6 years; and the average time working within approved premises is 62.6 months.

This Factor is again describing the function of how the staff team predictably manage problematic behaviours and create an environment that is safe from physical threat for staff and residents within the approved premise. Whilst there is some focus on structure and routine, this safety is established through the team being accessible to and providing for the residents to meet their needs, as well as limiting independent or autonomous behaviour and decision making by the residents.

The predominant collective viewpoints offered by staff within this Factor again relate to there needing to be an environment where individuals are safe from physical threat from each other (27; 5) where there is also no real emphasis placed on creating a sense of emotional safety to be able to share thoughts and emotions with each other (49; -1). Public protection and a focus on public safety is also a core defining element of this Factor (36; 3) supported by there being a solid sense of coherence in working as an effective team (11; 4) who are confident in their ability to perform their roles and support residents (5; 4).

The staff identify with the relevance of interactions being enabling (26; 3) but what is strongly expressed by the staff within the approved premises in this Factor is that the residents need to be able to depend upon staff to help and support them (17; 5) with little investment in the experience of belonging to the community (46; 1) and the staff themselves taking little responsibility for implementing a sense of community (35; -3). The staff team are relatively confident in this approach as there is little need for understanding the reasons for how and why decisions are made (39; -3), they are not dependent upon guidance or leadership (25; -4) and are able to function with a sense of self-sufficiency and independence (4; 3). The staff team express an investment in understanding the residents as there is some thoughtfulness about the resident's strengths and skills (37; 2) but with primacy being upon their practical needs (10; 4) and not upon them being overtly included, involved and valued in the social processes (12; 2, 38; 2, 20; 2). As such where collaboration and alliance experienced between staff and residents is not a primary need as few goals about the culture of the environment in the approved premise are shared between staff and residents (19; 0). Similarly, staff often struggle to be openly accepting of the residents (31; 0) and they can take a judgmental and condemning approach to the resident's behaviours (42; 0, 34; -2). The residents are not encouraged to support or take care each other (24; -5, 8; -5).

Furthermore, within this Factor the staff team expressed that they are less clear about the social and interpersonal boundaries with the residents (45; 2) and they feel that they can be unpredictable and inconsistent in how they relate to the residents (33; -2). Although there is some need for routine (1; 1) in the approved premise to maintain a sense of safety and to uphold the public protection agenda, there is not an overt reliance by the staff to deliver predictable consequences for negative behaviours (43; -1). Similarly, there is not a primary focus in the need for clearly prescribed expectations about how residents behave socially and interpersonally (15; 0). However, this apparent flexibility in the team approach to ensuring safety from interpersonal threat coexists with the staff offering limited independence and self-determination to the residents, for example in not trusting or supporting residents to demonstrate autonomy in their actions or decision-making (41; -4, 16; 0).

Notwithstanding, although it is also thought important to hold in mind the general well-being and welfare of residents (3; 3) and to treat the resident's fairly and offer parity (40; 3), this level of thoughtfulness and consideration of the resident's needs does not clearly extend to an investment in understanding the resident's psychological or emotional well-being (50; 1). This is evidenced by a distinct lack of a genuine interest in each other (6; -4) and a limited sense of curiosity in or seeking understanding about why people behave in a certain way (13; -2, 7; -2, 32; -1). Likewise, staff do not tend to think about the impact of resident's behaviours on others or on the wider environment (21; 0) or think it important to keep in mind whether particular behaviours can be managed in the environment (44; -1).

Table 25 below outlines the distinguishing statements for Factor 2.1.

Table 25. Distinguishing Statements for Factor 2.1 (The Providing Team)

Statement Number	Statement	Factor 2.1 Q-SV	Factor 2.1 Z-score	Factor 2.2 Q-SV	Factor 2.2 Z-score
27	This needs to be a safe environment	5	2.27	4	1.66
17	Residents can depend on the staff to support them	5	1.88*	3	0.881
10	I am thoughtful about the resident's needs	4	1.54*	1	0.62
5	I am confident in how to support residents	4	1.45*	-1	-0.113
40	I treat others fairly	3	1.32	2	0.753
26	All interactions with residents should be enabling	3	1.19*	-1	-0.26
38	Everyone should be included	2	1.07*	-1	-0.373
45	The boundaries between staff and resident relationships are clear	2	0.99	4	1.553
20	I value the resident's contributions to the environment	2	0.77*	-3	-1.188
12	Everyone has a voice	2	0.73*	0	0.001
37	I think about the resident's strengths and skills	2	0.62*	-3	-1.261
23	I keep in mind the whole resident group, not just the individual	1	0.47*	-3	-1.195
2	We must be genuine / authentic in how we treat others	1	0.33*	-2	-0.753
28	We take care of our environment	1	0.31*	-2	-0.757
15	There need to be clear expectations about how people behave	0	0.08*	5	1.81
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	-0.01*	3	0.998
14	We can trust each other	0	-0.04	1	0.629
42	We take a non-judgemental approach	0	-0.18	1	0.405
31	We accept each other	0	-0.21*	-4	-1.33
16	We should encourage residents to make their own choices	0	-0.22*	-2	-1.146
19	We have shared goals about the culture between staff and residents	0	-0.29*	-2	-1.08
43	There needs to be predictable consequences for people's actions	-1	-0.33*	5	1.827
29	We accept that people make mistakes	-1	-0.35*	-4	-1.6
18	We need to be open to give and receive feedback	-1	-0.39*	1	0.627
32	I look at the person not the problem	-1	-0.52*	1	0.492
44	I keep in mind 'can we manage this type of behaviour'	-1	-0.58*	3	1.065
7	I do not take things at face value	-2	-0.71	-4	-1.386
47	I feel respected and valued	-2	-0.71*	1	0.482
13	I try to be curious in why people behave in a certain way	-2	-0.88*	0	0.129
4	I need to feel supported to do my job	-3	-0.95*	1	0.677
39	I need clear reasons for all decisions that are made	-3	-1*	2	0.722
48	I value supervision	-3	-1.07*	0	-0.096
6	We have a genuine interest in each other	-4	-1.38*	0	-0.027

25	I need strong leadership	-4	-1.65*	2	0.731

Note: p < 0.05; * indicates significance at p < 0.01

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this factor. For example;

> *"I go to support the residents and give them the positive support and feedback as much as I can. I am not here just going a job. It is about being a person and being personal".*
>
> (Participant A2)

> *"Being confident, I know I can support the residents in how I do my role and support the residents and a team in a way the AP is run… They can depend on us. It is important they can do this. It is important that we can be predictable and that we do what we say".*
>
> (Participant A4)

> *"I often think that my priorities are different depending on each day… We have to hope that the enabling environment is a strong enough concept to be able to bring new residents into the model when new residents arrive".*
>
> (Participant A5)

> "*In thinking about the residents and the staff, the residents always need help, they are here to access support… In relation to residents depending on staff… we have to support residents, it's the main reason why we are here".*
>
> (Participant A6)

"It's good to work together as a team. We've got to work together. We have got to be consistent to maintain that level of trust. Teamwork with the residents is important, especially leading by example. This is their home. We relate to the residents by engaging with them… Regarding residents depending on each other, residents can't depend on each other. They argue and they can't fully rely on each other. Staff have to relate to residents to be able to build the trust".

(Participant A8)

"About not being condemning, we have good and bad days, but this shouldn't define us as a person. No two days can be the same, but we do need consistency in the way that we communicate and the way that we relate to the residents. There needs to be a balance of looking after the residents and providing some responsibility for the community".

(Participant B2)

"… residents can depend on the staff to support them, they should depend on us, staff, for support not each other. We need to keep others' welfare in mind, both staff and residents and we need to look after each other".

(Participant C4)

7.3.3 Factor 2.2: Safe Containment

Factor 2 has an Eigenvalue of 2.88 and explains 16% of the study variance. Five participants are significantly loaded on this Factor, with four Offender Supervisors and one Residential Assistant. One participant is male, four are female; three participants were from ML approved premise, one was from MK and one was from GR; the mean age of the participants is 35.8 years; and the average time working within approved premises is 50.2 months. Of note, at this point of the data collection four out of the five participants loading on this Factor worked within the two approved premises markedly struggling with resourcing and staffing difficulties; and two of the strongest viewpoints loading on this Factor represent participants who worked in the approved premises that experienced both resourcing and staffing difficulties and who had struggled to manage a number of interpersonally aggressive residents that resulted in serious incidents.

The key narrative within this factor again relates to the focus being on how the staff team predictably manage problematic behaviours and create an environment that is safe from physical threat for staff and residents within the approved premise. Here this is undertaken through a clear problem-focussed approach with a team imposed procedure, rules, structure and consequences to problematic behaviours.

In this Factor there also needs to be an environment where individuals are safe from physical threat from each other (27; 4) with limited importance placed on creating a sense of emotional safety to be able to share thoughts and emotions with each other (49; 0). Public protection and keeping the public safe is also a core defining element of this Factor (36; 4) upheld through clearly prescribed expectations about how residents behave socially and interpersonally (15; 5). Similarly, these expectations exist within a system where working together as an effective staff team (11; 3) with the presence of overt social and interpersonal boundaries exist alongside routine and structure (45;

4, 1; 2). This allows the team to provide consistency in their approach to deliver predictable consequences for negative behaviours (43; 5) demonstrated by the residents within the approved premise.

What defines this Factor is that the staff team take a direct problem-focussed approach in managing difficult behaviours, where they are not openly accepting of the residents (31; -4) and it is expressed that they can also often take a judgmental and condemning approach to the resident's (42; -2, 34; -2). There is a clear risk management process implicit in the consideration as a team as to whether they are able to manage difficult behaviours demonstrated by the residents (44; 3) with little acceptance that mistakes are made (29; -4), and where interpersonal behaviours are often taken at face value (7; -4). There is a clear process of needing to manage problematic individuals in the approved premise through thinking about how these problematic behaviours impact others in the environment (21; 3, 23; -3).

Regarding the interpersonal culture of the approved premise as defined by this Factor, there is limited trust offered by staff towards the residents (14; 1), with the strong view that the residents are not thought to able to take care of each other or trusted to be able to depend on each other for mutual support within the approved premise (24; -5, 8; -5). Furthermore, it is not thought important that interactions between staff and residents need to be enabling (26; -1) and the staff offer limited independence and self-determination to the residents in not trusting or supporting the residents to demonstrate autonomy in their actions or decision-making (41; -3, 16; -2). What is also evident is that there is limited collaboration or alliance experienced between staff and residents as goals about the culture of the environment in the approved premise are not shared between staff and residents (19; -2) and staff take little responsibility for implementing a sense of community (35; -1). The staff team are not thoughtful about the resident's strengths, skills and needs (37; -4, 10; 1), residents are not offered the opportunity to have a say within the social

environment (12; 0), and they are not included, involved and valued in the social processes and decision making (38; -1, 20; -3).

Notwithstanding, there remains an underlying expression of a duty of care to the residents as staff have voiced that it is important to hold in mind the general well-being and welfare of residents (3; 2) and that they treat resident's fairly and offer parity (40; 2). Likewise, residents are able to depend on staff to support them (17; 3) but this is inauthentic, and staff do not express the confidence to be able to do this (2; -2, 5; -1).

Table 26 below outlines the distinguishing statements for Factor 2.2.

Table 26. Distinguishing Statements for Factor 2.2 (Safe Containment)

Statement Number	Statement	Factor 2.1 Q-SV	Factor 2.1 Z-score	Factor 2.2 Q-SV	Factor 2.2 Z-score
43	There needs to be predictable consequences for people's actions	-1	-0.33	5	1.83*
15	There need to be clear expectations about how people behave	0	0.08	5	1.81*
27	This needs to be a safe environment	5	2.27	4	1.66
45	The boundaries between staff and resident relationships are clear	2	0.99	4	1.55
44	I keep in mind 'can we manage this type of behaviour'	-1	-0.58	3	1.07*
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	-0.01	3	1*
17	Residents can depend on the staff to support them	5	1.88	3	0.88*
40	I treat others fairly	3	1.32	2	0.75
25	I need strong leadership	-4	-1.65	2	0.73*
39	I need clear reasons for all decisions that are made	-3	-1	2	0.72*
4	I need to feel supported to do my job	-3	-0.95	1	0.68*
14	We can trust each other	0	-0.04	1	0.63
18	We need to be open to give and receive feedback	-1	-0.39	1	0.63*
10	I am thoughtful about the resident's needs	4	1.54	1	0.62*
32	I look at the person not the problem	-1	-0.52	1	0.49*
47	I feel respected and valued	-2	-0.71	1	0.48*
42	We take a non-judgemental approach	0	-0.18	1	0.41
13	I try to be curious in why people behave in a certain way	-2	-0.88	0	0.13*
12	Everyone has a voice	2	0.73	0	0*
6	We have a genuine interest in each other	-4	-1.38	0	-0.03*
48	I value supervision	-3	-1.07	0	-0.1*

5	I am confident in how to support residents	4	1.45	-1	-0.11*
26	All interactions with residents should be enabling	3	1.19	-1	-0.26*
38	Everyone should be included	2	1.07	-1	-0.37*
2	We must be genuine / authentic in how we treat others	1	0.33	-2	-0.75*
28	We take care of our environment	1	0.31	-2	-0.76*
19	We have shared goals about the culture between staff and residents	0	-0.29	-2	-1.08*
16	We should encourage residents to make their own choices	0	-0.22	-2	-1.15*
20	I value the resident's contributions to the environment	2	0.77	-3	-1.19*
23	I keep in mind the whole resident group, not just the individual	1	0.47	-3	-1.2*
37	I think about the resident's strengths and skills	2	0.62	-3	-1.26*
31	We accept each other	0	-0.21	-4	-1.33*
7	I do not take things at face value	-2	-0.71	-4	-1.39
29	We accept that people make mistakes	-1	-0.35	-4	-1.6*

Note: p < 0.05; * indicates significance at p < 0.01

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this factor. For example;

> *"We as staff need to be a team… communication is key… If we don't communicate we can put someone in the community at risk… I think we do need a strong leader in this role. We need someone to take control, we need someone to be able to help us to deal with conflict with residents, to be able to say what needs to happen. Someone needs to take action and take an overview, to step in and set and maintain the boundaries".*
>
> (Participant A9)

> *"… residents can be unpredictable, and staff need to feel safe. We can't function and we can't work if we don't feel safe… there has to be clear consequences for actions. Things have to be consistent, they have to be predictable… if you are wishy washy then they can do what they like, but they also can feel more unsettled and more vulnerable… Residents tend to be not self-sufficient, but we need to help them*

to develop this. We need to follow this through. We need boundaries and implications for people's behaviour. People need boundaries and need to know what is expected…"

(Participant C2)

"Residents need to be able to speak about their emotional problems… They need to feel physically and emotionally safe, they need to know that there is support and that we are around".

(Participant C3)

"What they want is staff to be assertive in supporting them and not being inconsistent. Enabling is about better facilities to use to support the residents. The problem is that the environment can interfere with enabling them to progress".

(Participant A9)

"… we need to look at the person not the behaviour, unless risk takes a stance… Sometimes the person needs structure and an environmental security to support them. Enabling environments is about relational security, but sometimes we need the process and the environment… We therefore need to have clear boundaries to manage these relational elements".

(Participant B5)

"We need to be respected and valued. Often, we are not valued, and we are not respected and it can be a thankless job most of the time… boundaries are important. These are so important, like I don't tell them anything about myself… there is a relationship between the boundaries between self-disclosure and keeping a positive

professional relationship with the residents. It is difficult to keep this distance between social space and adhering to maintain this professional distance".

(Participant C6)

7.4 Discussion of the Findings

The analysis of the participants within the approved premises at Time Two was undertaken after each had each been engaged in implementing the Enabling Environment initiative for at least six months in their respective approved premises. The average time between data collection across the three approved premises was seven months, with the range being between 6 and 11 months. There were marked logistical difficulties encountered in the data collection at this stage due to staffing resources difficulties at two of the approved premises, and one of these had also struggled to manage a number of interpersonally aggressive residents that resulted in serious incidents. This is suggested to be influential in the findings at this time point.

The analysis revealed two interrelated viewpoints at Time Two that were however qualitatively different. As is consistent with the viewpoints described in Factor 1.1, both of the Factors yielded at this time point prioritise the necessity to create an environment that is safe from physical threat for staff and residents within the approved premise and public protection. Importantly, what is no longer evident in the viewpoints across both Factors at Time Two is any emphasis on creating a sense of emotional safety, value being placed on the forming and maintaining of meaningful interpersonal relationships and in including and accepting others or the creation of a sense of shared community focus. The defining viewpoints across these two Factors reflect a distinct separation in the systemic approaches applied by the staff to achieve the sense of safety that is held as being fundamental.

Factor 2.1 was termed '*The Providing Team*' as the viewpoints predominantly relate to staff focussing on being accessible to and available for the residents to meet their social and practical needs, but not their emotional needs. In order to support the strategy of residents being dependent on staff there is little encouragement for the residents to act with autonomy in their decision making or behaviour. This approach has some evidence in previous literature, in that the importance of staff being available and dependable to work collaboratively with the residents (Turley et al., 2013) and taking an understanding approach can influence service user's ability to remain engaged within services and increase desistance from problematic behaviour (Elisha et al., 2013). However, this is not wholly consistent with psychologically informed environments having a focus on the quality and nature of the interpersonal interactions and relationships to foster a sense of belonging, purpose and achievement (Haigh & Johnson, 2011).

In recent months there has been pervasive staffing resource difficulties and incidents of violence in two of the three the approved premises. It is understood that exposure to social conflict and assault are known to compromise staff well-being (Kelly et al., 2016), and it is suggested that being 'providers' for the residents can be a systemic strategy employed by the staff to ensure they are safe from threat and conflict (Green, 2018), as opposed to a way to encourage more meaningful social engagement. This akin to both 'yielding' strategies (Van der Helm & Stams, 2012) or 'pacifying' responses (Hamilton, 2010) pertinent in secure settings that are demonstrated by staff in response perceived physical threat to manage ongoing difficulties and to avoid future interpersonal conflict. Here, in order to maintain a sense of predictability and certainty in their environments, i.e. experiencing safety from threat, staff provide for the residents more unconditionally and are more compliant to the resident's needs. Notwithstanding, it is suggested that the staff within this Factor are trying relate to the residents in a meaningful way which is consistent with the research literature suggesting that supporting individuals practically and helping them solve their own problems occurs best within an organised environment, where staff

are able to impose controls and limitations where necessary (Davies, 2004b, Moos & Houts, 1968; Schalast et al., 2008).

Similarly, what is also evident within this Factor is that the staff experience much less clarity in their understanding of the social and interpersonal boundaries with the residents, there is a lack of confidence in relating to the residents and in understanding them emotionally, and there is less ability to rely on the presence of relational security. Boundaries are an interpersonal balance between staff and service users (Kennedy, 2002) which set limits, provide structure and create an atmosphere of safety that allows individuals to reflect on their experiences (Knapp & VandeCreek, 2012). Previous literature informs us that when clinicians are unclear or lacking in confidence about social and interpersonal needs, and indeed professional boundaries, their experience of certainty, safety, and predictability can be negatively impacted (Appleby, 2010; Budge, 2016). The viewpoints described in this Factor suggest that this process is occurring here as the staff described that they are inconsistent and unpredictable in how they relate professionally and interpersonally with the residents with less confidence in providing predictable consequences for problematic behaviours or in the application of clearly prescribed expectations about how residents behave socially and interpersonally. What the staff do express to address this is that they are confident in their approach in providing for the residents and can function with a greater degree of self-sufficiency and independence, which evidence does suggest is linked to increasing readiness to change (Ward et al., 2003).

What is also important to reflect on at this time point is that although the staff team have encountered difficulties within their respective environments unrelated to the Enabling Environment process, they have been engaged with the change process for at least six months. Davies et al. (2019) regard engaging in the Enabling Environment process as being an organisational and cultural change process, and the experience of change in any environment is often faced with

resistance (Bovey & Hede, 2001) which can destabilise and negatively impact the culture and therapeutic climate. This is suggested to be more incisive in environments where risk of harm and public safety are paramount within the culture and ethos of the environment. It is understood that although change may be viewed positively and as being beneficial, staff often experience a lack of understanding and uncertainty throughout change (Coulson-Thomas, 2009; Shaw, 2002). In this context this lack of certainty may extend to how the staff team attempt to integrate previously defined rules, structure and boundaries into new practice within the Enabling Environment process.

Factor 2.2 essentially parallels the viewpoints defined by the staff within Factor 1.1, i.e. clearly defined by how the staff team predictably manage problematic behaviours and create an environment that is safe from physical threat for staff and residents. Importantly in this Factor, three of the strongest viewpoints (out of the five) are from participants who are working within the approved premises that experienced both marked resourcing and staffing difficulties and had recently struggled to manage a number of interpersonally aggressive residents that resulted in serious incidents in and around the time of this data being collected. This is suggested to have influenced the way that these individuals see their environment and experience safety and is indicated by there being a clear problem-focussed approach with a team-imposed procedure, rules, structure and consequences to problematic behaviours. This is again consistent with the concept of containment (Haigh, 2013; Martin & Street 2003), with controlling responses identified by Clarke (1996) and in the Boundary Seesaw Model (Hamilton, 2010).

This Factor represents viewpoints that are more autocratic in their approach reflecting how the staff relate to residents at this time in their journey to becoming an Enabling Environment. This is understood by them as being reliant on procedural security to gain the necessary sense of safety to manage their anxiety of working with those who have are violent (Foster, 2001; Hamilton, 2010) whilst trying to understand the changes in the approach to working with residents. For example,

De Leon and Ziegenfus (1986) suggest that taking a hierarchical approach, i.e. having an imposed structure is often used to set or impose norms within an environment to gain a balance within that space. As such, there is little psychological understanding or interpretation of resident's behaviours as this is not a primary function, defaulting to understanding behaviour through a risk management and public protection filter, as well as through maintaining the overall safety of the environment. There is minimal collaboration or alliance expressed with the residents, little acceptance that mistakes are made, limited trust of the residents or responsibility for implementing a sense of community upheld by the staff.

Decisions are suggested to be made relative to the best interest of the function of the approved premise and around risk management rather than what is in the best interest of the residents themselves. These values are consistent with that suggested to be necessary for approved premises to be effective and responsive, i.e. having a well-led staff team who understand the key principles of the regime and how the team can be responsive to the risks and needs of the residents (Latessa & LowenKamp, 2002), but not consistent with what is enabling. Dallos and Draper (2010) argue that once negative relationship patterns exist there is a reactive tendency within the system itself that can also cause dysfunction. Here, it is suggested that the staff response to the increased stress as a result of limited staffing resources creating a lack of safety, exacerbated by experiencing interpersonal aggression may have precipitated an organisational response to the real threat that exists. As such, this Factor is termed '*Safe Containment'* as it represents a strategy of the approved premise to safely manage those who are regarded as the most difficult and hard to reach individuals with social, psychological difficulties and complex mental health needs (Johnson, 2009). The viewpoints in this Factor are also consistent with the national objectives of approved premises, i.e. that they provide a means to resettle and rehabilitate individuals moving into the community under the parameters of public protection within a risk management framework (HMIP, 2017).

We know that the culture of the organisation and the staff working within it are important to the functioning of these environments (Ward et al., 2003) and that consistency is important in the approach to managing individuals with complex needs (Turley et al., 2011). We also understand that the dilemma of managing risk and relationships has been found to be a struggle faced by staff in approved premises (Mason et al., 2008; Castledine, 2016), and at this time point there is a clear division in the viewpoints across the two Factors in how to best manage safety and unpredictable behaviours. The research literature around the notion of splitting within forensic contexts is relevant here (Green, 2018), especially that defined as being salient within a therapeutic milieu in response to aggression (Kernberg, 1992). Splitting is characteristically defined as different behaviours expressed about a group of individuals with a staff team becoming organised into groups with opposing perspectives (Gabbard, 1989; Green, 2018). At this time point, although there are not differences in opinions within a single team about problematic residents, there are two distinct polarized perspectives being derived from the analysis, one of which is to provide for and acquiesce to the residents and provide dependable practical support; and the other is to focus on containment with a lack of tolerance expressed for inappropriate and hostile behaviours. Both of these approaches have been suggested to impair therapeutic relationships and inhibit the effective functioning of therapeutic environments (Alexander & Bowers, 2004; Needham et al., 2005).

What is also important to reiterate is that this is an early stage in the development and implementation of the Enabling Environment process. As such, because it is understood that the staff have a role in the development and upkeep of the structure and function of the milieu (Peplau, 1989), it is not uncharacteristic that the staff are 'finding their feet' to understanding and implementing the Enabling Environment initiative.

Chapter Eight:
Study Two (Part A) - Time Three (Approved Premise Staff Participants)

8. Results: Approved Premise Staff Time Three

8.1 Overview

The data entry processes and the software that was used remained the same within this process of analysis as was sued in Chapter Six. The timepoints at which the data was collected is also detailed in Chapter Six.

8.2 Q Analysis at Time Three

8.2.1 *Factor Extraction*

From the 18 participants in Time Three, using KEN-Q Analysis, two Factors were again extracted and used for interpretation, therefore meaning that there were two distinct and meaningful patterns that the participants sorted their statements into.

The Correlation Analysis can be found in Appendix 20.

KEN-Q Analysis was used to subject the 18 Q-Sorts to the by-person Q-Factor Analysis within Q Methodology. Again, a Centroid Factor Analysis using Varimax Rotation was used to generate possible factor solutions. As before, minor Manual Rotations were also attempted within the analysis to try to maximise the number of participants that significantly load on any one factor (+/- up to 90° in 10° increments), however any Manual Rotations that were undertaken did not increase the interpretability of the data.

As with the analysis of time One and Two, analysis began by extracting a four-factor solution, and subsequently factor solutions for two to four Factors were computed for thoroughness. Table 27 below provides a quantitative summary of the two, three and four-factor solutions.

Table 27. Summary of the Different Possible Factor Solutions at Time Three

Factor Solution	No. of Factors with Eigenvalue >1	No. of Factors meeting Humphrey's Rule	No. of Factors with Two significantly loading participants	Total No of participants accounted for in the solution	No. non-significant / confounding Participants	Amount of Variance Explained
Two	**2**	**2**	**2**	**13**	**5**	**36%**
Three	2	2	2	12	6	37%
Four	2	2	2	12	6	42%

Table 27 above details that each of the factor solutions resulted in only two Factors meeting the Kaiser-Guttman Criterion, Humphrey's Rule and there being a minimum of two participants who load significantly on each Factor. A two-factor solution resulted in both Factors having more than two participants significantly loading and where both Factors met the Kaiser-Guttman Criterion and Humphrey's Rule. Furthermore, although the three and four-factor solutions explained a greater degree of variance, when these were qualitatively explored the two-factor solution was most representative of the data and allowed for a thorough and informative account of the data. The two-factor solution is suggested to explain a robust degree of variance in this data.

As such, through incorporating each of the six aspects outlined above, the two-factor solution, yielding the two extractable and usable Factors was chosen because; (1) it prioritised the solution with robust explained variance, (2) it minimised the number of Factors that were extracted without any significant factor loadings, (3) each of the usable factors met the Kaiser-Guttman Criterion and Humphrey's Rule, and (4) the data qualitatively best represented the data and each factor extracted made an original contribution to understanding the data.

Therefore, in regard to the final factor solution, a two-factor solution was found to be most representative of the data, and as such two Factors were retained for the analysis. Together, these two Factors explained 36% of the variance. 13 of the 18 Q-Sorts loaded significantly over these two Factors, i.e. with a loading of ±0.36 being significant at the $p < 0.01$ level. Four Q-Sorts were found to be non-significant and one was confounding.

Table 28 below demonstrates the factor loadings for the two Factors extracted.

Table 28. Rotated Factor Loadings for the Factors at Time Three

Q sort	Factor 3.1	Factor 3.2
A2	**0.5151***	-0.0137
A4	-0.1521	0.2581
A5	0.2981	**0.6545***
A6	0.5357	0.5091
A7	0.3563	**0.3605***
A8	0.0866	0.2901
A9	**0.4516***	0.3539
B1	0.3342	**0.5799***
B2	-0.1172	**0.5283***
B5	**0.456***	0.1911
B6	0.322	**0.6442***
B7	0.2237	0.2523
B8	0.0739	0.1459
C1	**0.5792***	0.2833
C2	**0.7725***	0.0726
C3	**0.7369***	0.2636
C4	0.1536	**0.6756***
C5	**0.7251***	0.0151
Eigenvalue	**3.6**	**2.88**
Humphrey's Rule	**0.57**	**0.43**
Explained variance (%)	**20**	**16**

Note: (*) denotes the participants that loaded significantly on each Factor.

8.2.2 Factor Arrays

The factor arrays, i.e. the merged average complete Q Sorts that make up each Factor can be found in Appendix 21.1 and 21.2). Table 29 below demonstrates the relative rankings given to each statement within each Factor for Time Three.

Table 29. Factor Arrays for each of the two Factors at Time Three

	Statements	Factor 3.1	Factor 3.2
1	There needs to be a clear routine to the environment	0	-1
2	We must be genuine / authentic in how we treat others	1	2
3	I keep others welfare in my mind	0	4
4	I need to feel supported to do my job	3	-3
5	I am confident in how to support residents	2	1
6	We have a genuine interest in each other	-3	-1
7	I do not take things at face value	-2	1
8	Residents can depend on each other	-5	-5
9	We value everyone's ideas / thoughts	1	-2
10	I am thoughtful about the resident's needs	0	1
11	We work together as a team	4	4
12	Everyone has a voice	0	-1
13	I try to be curious in why people behave in a certain way	2	1
14	We can trust each other	3	0
15	There need to be clear expectations about how people behave	4	-1
16	We should encourage residents to make their own choices	-1	2
17	Residents can depend on the staff to support them	1	3
18	We need to be open to give and receive feedback	1	0
19	We have shared goals about the culture between staff and residents	-1	-2
20	I value the resident's contributions to the environment	-2	-2
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	2
22	I try to be a pro-social role model	2	1
23	I keep in mind the whole resident group, not just the individual	-4	0
24	Residents are able to take care of each other	-5	-4
25	I need strong leadership	-2	-3
26	All interactions with residents should be enabling	0	3
27	This needs to be a safe environment	5	3
28	We take care of our environment	-2	-4
29	We accept that people make mistakes	-1	1
30	Residents can predictably get support when they need it	0	0
31	We accept each other	-3	-3
32	I look at the person not the problem	-1	-1
33	We relate to each other with a sense of consistency and predictability	2	-2
34	Not being condemning of others behaviour	-1	0
35	I take responsibility for a sense of a community	-4	-5
36	I ask myself about the need to keep the public safe	1	5
37	I think about the resident's strengths and skills	-2	-1

38	Everyone should be included	-4	2
39	I need clear reasons for all decisions that are made	2	-3
40	I treat others fairly	3	3
41	We allow everyone to have some autonomy	-3	-1
42	We take a non-judgemental approach	0	4
43	There needs to be predictable consequences for people's actions	4	0
44	I keep in mind 'can we manage this type of behaviour'	1	1
45	The boundaries between staff and resident relationships are clear	5	5
46	We help each other to feel that they belong	-1	0
47	I feel respected and valued	3	-4
48	I value supervision	-3	-2
49	Feeling safe to share our thoughts and emotions	-1	2
50	I am thoughtful about how others feel	1	0

8.2.3 Relationship between the Factors

Table 30 below details the correlation scores between the two Factors derived from this analysis in Time Three. The Q analysis revealed that although there are two distinct viewpoints described by the participants, there is a moderate positive relationship between the two collective viewpoints expressed.

Table 30: Correlations Between Factor Scores at Time Three

	Factor 3.1	**Factor 3.2**
Factor 3.1	1	
Factor 3.2	0.4612	1

8.3 Interpretation of the Factors at Time Three

8.3.1 Overview

A narrative style (Watts & Stenner, 2012) was again used as well as the 'Crib Sheet' approach (Watts & Stenner, 2012) to assist in the interpretation of the Factors (Appendix 22.1 and 22.2). The Consensus Statements can also be found in Appendix 22.3.

8.3.2 Factor 3.1: Safety in the Environment

Factor 1 has an Eigenvalue of 3.6 and explains 20% of the study variance. Seven participants are significantly loaded on this factor with five Offender Supervisors and two Residential Assistants. Three of these are male and four are female; four participants were from ML approved premise, two were from MK and one was from GR; the mean age of the participants is 41.1 years; and the average time working within the approved premise is 78.1 months.

The viewpoints shared within this Factor are again very closely associated with that found in Factor 1.1 and surround how the staff team predictably manage problematic behaviours and create an environment that is safe from physical threat for staff and residents within the approved premise, but without an external focus on a public protection agenda. This is again established through the team setting up and implementing staff-directed procedure, rules, structure and consequences.

There is again a need to establish an environment where individuals are safe from physical threat from others (27; 5) without any importance placed on creating a sense of emotional or interpersonal safety to be able to share thoughts and emotions with each other (49; -1). Maintaining this safe environment is supported by clearly prescribed expectations about how

residents behave socially and interpersonally (15; 4) upheld by an effective staff team that has trust in each other but also towards the residents (14; 3, 11; 4, 47; 3), who hold clear and overt social and interpersonal boundaries (45; 5). This results in the team who provide a consistency in their approach to deliver predictable consequences for negative behaviours demonstrated by the residents within the approved premise (43; 4).

However, within this Factor the emphasis upon public protection is not a core defining element (36; 1) and neither is a view that interactions need to or should be enabling (26; 0). Whilst supervision and leadership are not valued (48; -3, 25; -2), clear reasons for decisions are often needed (39; 2) as is needing to feel supported by other team members to undertake their role (4; 3).

With regard to the interpersonal culture within the approved premises, there is minimal inclusion or involvement of the residents in the social processes or decision making (38; -4) and the focus tends to be on problematic individuals rather than thinking about the resident group as a whole (23; -4) or on how this impacts on others in the environment (21; 0). This is further exemplified by staff expressing that they have a limited genuine interest in others (6; -3), that they often struggle to be openly accepting of the residents (31; -3), and can at times take a judgmental and condemning approach to the resident's behaviours (42; 0, 34; -1). Furthermore, staff tend to be inconsiderate of resident's strengths and skills (37; -2), there tends to be a focus on problems rather than on understanding the resident's behaviours (32; -1) and limited acceptance that the residents can make genuine mistakes (29; -1).

Importantly, there is some meaningful sense of curiosity in seeking to understand why the residents behave in a certain way (13; 2), the staff attempt to offer some consistency and predictability in their approach to the residents (33; 2) and there is also an underlying expression that they treat residents fairly and offer parity (40; 3). However, they do not always keep the resident's welfare in

mind (3; 0) and there is limited collaboration or alliance experienced between staff and residents as goals about the culture of the environment in the approved premise are not shared between staff and residents (19; -1). Staff identify that they often take things at face value (7; -2) and valuing resident's thoughts and ideas is not a high priority (9; 1). What is also strongly expressed by the staff within the approved premises at this time point is that residents are not encouraged to support or depend each other (24; -5, 8; -5) and autonomy and independent decision making are not openly supported (41; -3, 16; -1).

Table 31 below outlines the distinguishing statements for Factor 3.1.

Table 31. Distinguishing Statements for Factor 3.1 (Safety in the Environment)

Statement Number	Statement	Factor 3.1 Q-SV	Factor 3.1 Z-score	Factor 3.2 Q-SV	Factor 3.2 Z-score
27	This needs to be a safe environment	5	2.39*	3	1.362
15	There need to be clear expectations about how people behave	4	1.87*	-1	-0.197
43	There needs to be predictable consequences for people's actions	4	1.55*	0	0.03
4	I need to feel supported to do my job	3	1.42*	-3	-1.082
47	I feel respected and valued	3	0.95*	-4	-1.563
14	We can trust each other	3	0.94*	0	0.091
39	I need clear reasons for all decisions that are made	2	0.73*	-3	-1.141
33	We relate to each other with a sense of consistency and predictability	2	0.56*	-2	-0.909
9	We value everyone's ideas / thoughts	1	0.38*	-2	-0.59
36	I ask myself about the need to keep the public safe	1	0.37*	5	1.656
17	Residents can depend on the staff to support them	1	0.32*	3	1.354
3	I keep others welfare in my mind	0	0.24*	4	1.439
42	We take a non-judgemental approach	0	0.15*	4	1.368
26	All interactions with residents should be enabling	0	-0.2*	3	1.317
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	-0.33*	2	0.474
29	We accept that people make mistakes	-1	-0.4*	1	0.444
49	Feeling safe to share our thoughts and emotions	-1	-0.45*	2	0.831
16	We should encourage residents to make their own choices	-1	-0.47*	2	0.829
25	I need strong leadership	-2	-0.56	-3	-1.187
7	I do not take things at face value	-2	-0.59*	1	0.329
28	We take care of our environment	-2	-0.73*	-4	-1.527
6	We have a genuine interest in each other	-3	-1.11	-1	-0.494
41	We allow everyone to have some autonomy	-3	-1.26*	-1	-0.517
38	Everyone should be included	-4	-1.32*	2	1.091
23	I keep in mind the whole resident group, not just the individual	-4	-1.36*	0	-0.056
24	Residents are able to take care of each other	-5	-2.12*	-4	-1.377

Note: $p < 0.05$; * indicates significance at $p < 0.01$

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this factor. For example;

"Keeping clear boundaries and expectations keeps us safe and it keeps the residents safe… people have to know that there are rules and that there are ways of doing things, and that there are clear expectations of them as residents. This reduces ambiguity".

(Participant A9)

"Working together as a team, the job is hard enough. We do just need to work together… we have to rely on them, we have to rely on each other for support".

(Participant A2)

"… there is a split role between supervision work and support in the approved premise... There needs to be more time focussed on the residents and giving the residents the coping skills to be able to reduce their risk… we need to be mindful of risk and this needs to be managed at the AP… Can we help them manage their risk and follow their licence conditions, like can we adequately support them".

(Participant B5)

"*We need to accept each other. We need to think about community. People need to have a voice. We need to be genuine and we need to be genuine in how we treat each other".*

(Participant C1)

"*We need to get the basics right, like creating a safe environment and an environment that can be enabling. We need to be clear on why we are here and what is the purpose we serve".*

(Participant C5)

"… there has to be consequences for problematic behaviour. Residents need to know the consequences for their actions. For example, if they do (a) then (b) will happen. They need to understand how they should behave and how they should relate to each other… I think the environment needs to be safe for staff and residents so that staff can protect themselves".

(Participant C2)

"…they [residents] have to depend on us. They have to be able to approach staff first to think about their problems. Staff do offer support and they offer shared experiences, but they do need to go to rely on staff first".

(Participant C3)

"We have to be non-judgemental, we have to keep others in mind and give others a chance… It is important to not take things at face value, we are humans. The residents are humans. We all have feelings… Trust has to be built with all of the residents."

(Participant C4)

"We need to be accepting that people make mistakes, but we also need to bear in mind there are rules and there need to consequences. We are helping residents go through a process, they need to be able to see the difference from last time to now".

(Participant C6)

8.3.3 Factor 3.2: Understanding Our Impacts

Factor 2 has an Eigenvalue of 2.88 and explains 16% of the study variance. Six participants are significantly loaded on this factor with one Manager, three Offender Supervisors and two Residential Assistants. One participant is male and five are female; three participants were from GR approved premise, two were from MK and one was from ML; the mean age of the participants is 41 years; and the average time working within therapeutic environments is 76.7 months.

The overall narrative in this Factor surrounds the presence of balancing the management of risk and public protection with building authentic relationships with the residents that are person-centred and non-judgemental. This is attempted through a team confident in their professional boundaries and professional purpose that focus on the welfare of the residents.

The staff viewpoints expressed in this Factor relate to the need to maintain an environment where individuals are safe from physical threat from each other (27; 3), but with the presence of an emotionally safe environment where there is some encouragement and support for the residents to share their thoughts and emotions with each other (49; 2). Public protection and a focus on public safety do exist as a core defining element of this Factor (36; 5) whilst the staff team also share an understanding that interactions between staff and residents should be enabling where possible (26; 3).

There is a solid sense of coherence in working as an effective team (11; 4) with limited focus on the need for clearly prescribed expectations about how residents behave socially and interpersonally (15; -1), and minimal reliance on the provision of clear structures or routines in the environment or the need to stipulate predictable consequences for negative behaviours (1; -1, 43; 0). There is a sense of confidence held about this position because staff expressed that they do not need to feel

supported or respected to undertake their roles (4; -3, 47; -4), they did not need strong leadership to maintain this position, and that they do not always need clear reasoning for decisions that are made (25; -3, 39; -3).

The staff identified that they hold clear social and interpersonal boundaries between themselves and the residents (45; 5) and attention is paid to both addressing and thinking about how negative behaviours can impact others in the environment (21; 2, 7; 1), however with a problem-orientated focus being more prevalent (32; -1). Residents are encouraged where possible to make their own choices (16; 2), there is a clear determination to take a non-judgemental approach to relating to the residents and in understanding their behaviours (42; 4), residents are able to depend upon staff to help and support them (17; 3) and they identify that being inclusive, genuine and authentic is helpful to the way that they engage with and relate to the residents (38; 2; 2; 2).

However, the staff express some lack of confidence in their ability to support the residents (5; 1) and they feel that they can be unpredictable and inconsistent in how they relate to and provide emotional support to the residents (33; -2, 30; 0). Also, although it is clearly thought to be essential to hold in mind the general well-being and welfare of residents and to treat them fairly and with equality (3; 4, 40; 3), they are not openly trusted (14; 0) and thoughtfulness and consideration of the resident's needs does not openly extend to an investment in understanding the resident's psychological or emotional well-being (50; 1). Staff are not openly accepting of the residents and are they not encouraged to have a say in the culture of the environment (12; -1, 31; -3), the staff take no responsibility for a implementing a sense of community or in investing in the experience of belonging to the community (46; 0, 35; -5), and there are few goals about the culture of the environment shared between staff and residents (19; -2). Similarly, the resident's Ideas are not often valued and nor are their contributions to the environment (9; -2, 20; -2). There is also a strong

position held that the residents are not thought to able to take care of each other or trusted to be able to depend on each other for mutual support within the approved premise (24; -5, 8; -5).

Table 32 below outlines the distinguishing statements for Factor 3.2.

Table 32. Distinguishing Statements for Factor 3.2 (Understanding Our Impacts)

Statement Number	Statement	Factor 3.1 Q-SV	Factor 3.1 Z-score	Factor 3.2 Q-SV	Factor 3.2 Z-score
36	I ask myself about the need to keep the public safe	1	0.37	5	1.66*
3	I keep others welfare in my mind	0	0.24	4	1.44*
42	We take a non-judgemental approach	0	0.15	4	1.37*
27	This needs to be a safe environment	5	2.39	3	1.36*
17	Residents can depend on the staff to support them	1	0.32	3	1.35*
26	All interactions with residents should be enabling	0	-0.2	3	1.32*
38	Everyone should be included	-4	-1.32	2	1.09*
16	We should encourage residents to make their own choices	-1	-0.47	2	0.83*
49	Feeling safe to share our thoughts and emotions	-1	-0.45	2	0.83*
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	-0.33	2	0.47*
29	We accept that people make mistakes	-1	-0.4	1	0.44*
7	I do not take things at face value	-2	-0.59	1	0.33*
14	We can trust each other	3	0.94	0	0.09*
43	There needs to be predictable consequences for people's actions	4	1.55	0	0.03*
23	I keep in mind the whole resident group, not just the individual	-4	-1.36	0	-0.06*
15	There need to be clear expectations about how people behave	4	1.87	-1	-0.2*
6	We have a genuine interest in each other	-3	-1.11	-1	-0.49
41	We allow everyone to have some autonomy	-3	-1.26	-1	-0.52*
9	We value everyone's ideas / thoughts	1	0.38	-2	-0.59*
33	We relate to each other with a sense of consistency and predictability	2	0.56	-2	-0.91*
4	I need to feel supported to do my job	3	1.42	-3	-1.08*
39	I need clear reasons for all decisions that are made	2	0.73	-3	-1.14*
25	I need strong leadership	-2	-0.56	-3	-1.19
24	Residents are able to take care of each other	-5	-2.12	-4	-1.38*
28	We take care of our environment	-2	-0.73	-4	-1.53*
47	I feel respected and valued	3	0.95	-4	-1.56*

Note: $p < 0.05$; * indicates significance at $p < 0.01$

The following additional qualitative information is drawn from the post card sort interviews to further help describe the core notions and themes that underpin this factor. For example;

> *"If we don't work together as a team, things can break down... it just doesn't work. We need to rely on others and rely on each other. If we are not a team then we just get splintered… Here, boundaries are really important. We have to work like a team, we all have to have boundaries, we all have to be consistent or things will be at risk…. For me it is a balance of public protection and supporting the residents... between getting the job done and the community… For example, balancing and supporting a resident when he is also telling you about increased risks."*
>
> (Participant A5)

> *"We can't do our job if we are judgemental. We need to be non-judging about their offence or their heritage. They are human beings and I am working with human beings. I need to think "who is this standing here with me? I will try and help them, and I will try and help them work with their difficulties…"*
>
> (Participant A7)

> *"I think we need to be direct, open and fair. Molly coddling is not helpful. It is important to be consistent and to treat people openly and fairly so I can more safely make a decision… I need to ask residents to talk to me. I need to make it clear that they can and if they need something that they can understand and expect that from me. I like to be predictable, it is good to be reliable so that we can also rely on the residents."*
>
> (Participant B1)

"There are dilemmas in working here. The dilemmas of public protection, so balancing the risk and relationships with residents. There needs to be shared goals between staff and residents. Staff have to work here in line with supervision from probation officers and their sentence plans, but also helping the individuals manage their own needs and manage what the resident wants".

(Participant B2)

"… everyone should be included. This is both with residents and staff. If they don't feel included then they won't want to engage. If we increase responsibility and well-being we also increase their sense of responsibility and autonomy."

(Participant B3)

"Regarding a non-judgemental approach, we need to treat the person like a person, not like the offence, we don't need to think about the offence or the time. We need to keep an open mind".

(Participant B6)

8.4 Discussion at Time Three

The analysis of the participants at Time Three was undertaken after they had each been engaged in implementing the Enabling Environment initiative for at least 12-18 months. At the time of this third data collection period, two of the three approved premises involved were continuing to be actively working towards the Enabling Environment award, with one of these planning to submit the portfolio within the forthcoming eight weeks. The other approved premise had achieved the Enabling Environment Award at the time of this last phase of data collection.

The Analysis at Time Three identified two distinct but more closely associated Factors. Factor 3.1 is termed '*Safety in the Environment',* as although the viewpoints are very closely associated with those initially expressed in Factor 1.1 and then in Factor 2.2, i.e. surrounding needing structure and process through procedural security to ensure safety (Reed, 1994), there is a more central focus on the system within the approved premise rather than on public protection objectives that exist within the wider framework.

It continues that it is safer and more consistent to impose rules and consequences than to rely upon meaningful relationships with residents to understand risk, and that this reflects a systemic approach used to achieving the sense of safety that is needed. Overall there remains an autocratic approach to engaging with the residents and decisions are made relative to the best interest of the function of the approved premise and not what is in the best interest of the residents. There is little sense of shared community or placing value in the notion of belonging to the collective group of residents. Given the recent experienced lack of safety due to staff resources and aggressive incidents, again this might be understood by the continued reliance on procedural security to gain the necessary sense of safety to manage their anxiety of working with violent individuals (Foster, 2001).

There remains a close experience of teamwork that hold clear and predicable boundaries to secure a sense of interpersonal safety for the staff and the residents. This remains an important concept given the findings that to have effective working with high-need and challenging client groups there is a need for strong team interactions as well as good communication and integration between team members (Buljac-Samardzic et al., 2011). Furthermore, these boundaries and structures analogous to the principle of containment (Haigh, 2013; Martin & Street 2003) also exist whilst the staff group are more curious about the resident's and offer some consistency and predictability in

their approach to them. This is relevant given that the way staff and residents interact can impact psychological and social progress (Bolger & Turner, 2013) and can influence effective communication (Livesley, 2007).

There is a presence in the focus being towards care being expressed for the residents and not centred around an external public protection or risk management agenda. This links to previous research literature that identifies a key importance of understanding that the function and nature of the psychological relationships in such environments is a central element of the psychological containment for both offenders and staff (Brown, 2014). Similarly, an element of this Factor that is different to previous timepoints is the greater presence of a willingness to trust residents within the environment, which is suggested to be emerging because staff do not prioritise their focus on risk management and public protection as this is confidently held as a position. They are more able to think about what is happening within the approved premise as opposed to what is expected from the wider criminal justice system, and it is suggested that the staff group are beginning to work from a set of principles on how to relate to each other as opposed to adherence to rules and process. It is understood that trust is regarded as a scaffold needed for effective relationships to develop within forensic settings (Askola et al., 2017; Cleary, 2003), and although it remains fundamentally safer to impose expectations and rules, being inquisitive about how and why residents present and behave when experiencing difficulties is evident, which is integral to healthy social relating (Joseph & Benefield, 2012; Turley et al., 2013). Staff however are not confident to trust their judgements in and around this as they identify that they need support in thinking this way. This is important as it has been found that if individuals working with complex needs are not well managed or unsupported, there can be negative consequences to both psychological and emotional well-being (Elliot & Daley, 2012; Link et al., 2010; Scott, 2006).

The viewpoints in Factor 3.2 are termed '*Understanding Our Effects*', and they reflect a greater synthesis in understanding the provision of both safety from threat and ensuring a safe relational space for the residents to think about and share their thoughts and emotions. There is a clearer and more open understanding of the need for both managing risk through a public protection framework and offering an environment for the residents that holds relating to others as being important through awareness of how behaviours impact on others. This is a positive finding at this stage as the conflict experienced by staff between performing a therapeutic role and a public protection function can be detrimental to effective delivery of psychologically informed environments (Castledine, 2016).

Although there is an emphasis on public protection and risk management, there is confidence that this is not solely facilitated through a reliance on procedural security with structured or rigid routine, consequences for actions or clearly defined expectations for behaviour. What is most evident in this Factor is the emphasis on taking a non-judgemental approach in understanding and relating to the residents whilst also being inclusive, genuine and authentic in the way that they engage with and relate to the residents. This is indicative of there being a developing emphasis on a therapeutic relationship between staff and residents which the research literature tells us are core aspects of a relationship-orientated environment (Turley et al., 2013; Van Kessel & Van der Linden, 1991) and a central factor in engaging individuals with complex needs in a therapeutic process (Howells & Day, 2007).

These viewpoints are suggested to be the beginning foundations to a more effective social milieu and may represent the presence of the team relying more on their ability for independent thoughtfulness rather than on rules, where the team are beginning to trust themselves to work out the correct responses to given situations consistent with the developing view of an Enabling Environment. These findings are consistent with the view that the Enabling Environment process is

not a ‘mechanism for change’ but a schematic to identify what needs to be thought about within the environment to establish that culture (Davies et al., 2019). Relating without judgement within forensic settings is defined as seeing people as individuals and not defining them by their offending behaviour (Gildberg et al., 2012; Thorpe et al., 2009) and alongside trust, this is regarded as a fundamental quality for both staff and service users in forensic settings (Marshall & Adams, 2018). Supportive of this within the viewpoints of this Factor is a foundation in thinking more psychologically, thoughtfully and understanding the relationship between individuals themselves and the wider approved premise community. This is suggestive of the relationships between the staff and residents being orientated towards thinking about the causal impacts of actions upon others, although this is more focused upon the extrinsic behavioural impacts and not the intrinsic emotional consequences. These elements are suggested to be a recognition of the dual roles staff members have when offering therapeutic and risk management frameworks that have been found to be important to navigate (Marshall & Adams, 2018); and a fundamental construct in the application of the Enabling Environment initiative within approved premises because they invariably have a risk management function.

Across both Factors put forward at this time point there is a greater coherence in understanding the need for interpersonal and emotional safety and how this is delivered within an environment where the need for public protection and therapeutic engagement with the residents is relevant. Residents are treated with care, compassion and parity, where they are encouraged to think about their relationships with others, supported by the consistent and predictable relationships with staff individually and as a team. Essentially, here at the third timepoint, after approximately 12-18 months of engagement in the Enabling Environment process both factors outline the early presence of a meaningful social climate where staff can foster and promote an interpersonal and relational ethos, as well as an experiential ethos (e.g. Johnson & Haigh, 2011) within an organisation dedicated to working with complex individuals within a public protection framework. Similarly, the

presence of relational security (Appleby, 2010) is pertinent to approved premises at this stage in their place in the public protection framework because the process of understanding the functions of relationships and to help residents develop more responsibility for their difficult behaviours is hoped to aid the management of risk (Joseph & Benefield, 2012; Turley et al., 2013).

To a greater or lesser degree each of the five core principles suggested to be required to have effective social and therapeutic climates (Haigh, 2013) are present across these two Factors; i.e. having belonging and connection to others (Attachment), experiencing the environment as a safe place (Containment), there being open and non-judgemental communication (Communication), being encouraged to be a functional part of the environment (inclusion), and being encouraged to understanding their own abilities and have a sense of influence on their own lives (Agency).

Chapter Nine:
Study Two (Part B) - Exploration of the Viewpoints Across Time

9. Results: Correlational Analysis and Qualitative Comparisons

9.1 Overview

Chapters Six, Seven and Eight outline the findings at each of the three timepoints that was analysed and interpreted separately as independent Q-Sorts, offering a 'snapshot' or cross-sectional interpretation of how the participants experience the approved premise environment at each of the timepoints. Here, Study Two (Part B) aims to explore and compare these separate analyses as a connected time series to explore the qualitative differences in the viewpoints expressed towards this therapeutic environment over time.

This time series analysis took two forms. Firstly, a quantitative analysis undertaken using a Bivariate (Pearson) Correlation was used to explore the relationships between the Factors derived at each of the three timepoints with the Factors that comprise the 'Prototype' of an ideal Enabling Environment (as defined in Study Two – Part A). This correlation analysis was undertaken using SPSS. These two methods will be explored together in the Discussion section of this Chapter.

Secondly, this quantitative process was supported with a qualitative interpretation exploring the similarities and differences between the factors derived from the analyses at the three timepoints to explore changes in the way participants experienced the approved premises as they have progressively been engaged in the Enabling Environment initiative.

9.1.1 Overview of the Factors derived from Study One

Table 33 below outlines a brief description of the three Factors extracted from the Analysis of the Expert Participants in Study One.

Table 33. Summary Description of the Three Expert Factors

Factor A: *The Safe Relating Space*	• Safe to share thoughts and emotions • Value in the meaning of the relationships, in relatedness to others and relational security • The presence of emotional containment in the relationships • A curious non-judgemental approach needed with openness to feedback • Importance placed on inclusion and acceptance • Not problem focussed or risk / public protection orientated • The creation of a community and of sense of belonging where ideas are valued, and everyone has a voice
Factor B: *The Predictable System*	• Importance on safety and procedural security • Need for routine, structure and expectations but without clear consequences needed • Clear interpersonal boundaries are present • Safety sought through the team structure and being predictable available • Residents can depend upon staff • Value also placed on social inclusion, offering autonomy, offering a voice and valuing ideas
Factor C: *The Modelling Team*	• Need for safety from harm and to feel safe to share thoughts and emotions • Need for clear expectations for residents but without reliance upon consequences for behaviour or structure / routine • Balance of procedural and relational security is present • Clear interpersonal boundaries • Public protection is an objective • Safety is sought through the team modelling pro-social behaviour, communication and feedback • Developing a sense of community is important but not of inclusion or belonging • Provision of an environment that is fair, where strengths are considered, and individuals are valued

9.1.2 Overview of the Factors derived from Study Two (Part A)

Table 34 below outlines a summary description each Factor extracted from the Analysis of the participants at each of the three timepoints. Furthermore, Figure 2 below also emphasises the exploratory relationships between the Factors at the three timepoints.

Figure 2. Hypothesised Relationships Between the Factors at the Three Timepoints

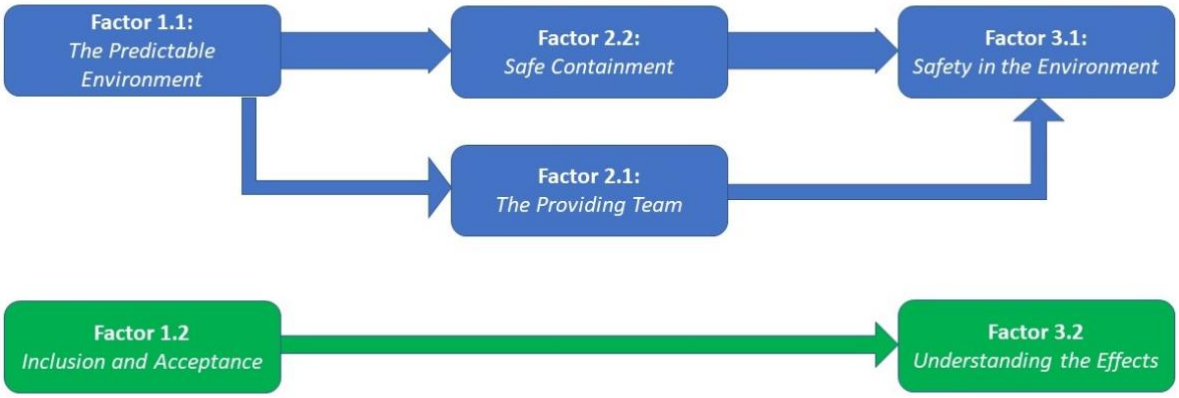


Table 34. Summary Description of the Factors at Each Time point

Time 1	**Factor 1.1:** *The Predictable Environment*	• Need for safety within the environment • Public protection is a clear objective • Need for routine, structure and consequences with clear boundaries • Safety through procedural security • Teamwork to impose structure • Prescriptive approach without shared goals or community • Limited trust offered to the residents • Welfare and practical needs of residents are important
	Factor 1.2: *Inclusion and Acceptance*	• Safe to share thoughts and emotions • Including and accepting others is a priority • Clear interpersonal boundaries • Openness, transparency and collaboration between staff and residents • Relational security more prevalent • Sense of community and belonging is important • Teamwork modelling democratic and inclusive pro-social approaches

Time 2	**Factor 2.1:** *The Providing Team*	• Need for safety within the environment • Interpersonal boundaries are less clear • Less focus on routine, structure and consequences • Safety achieved through being available for and providing for residents. • Limited autonomy encouraged • A team that are focussed on meeting the resident's practical needs
	Factor 2.2: *Safe Containment*	• Need for safety and managing the safe environment • Need for routine, structure, boundaries and consequences • Public protection is a clear objective • Clear presence of a problem focussed approach • Focus on whether behaviours can be managed • Safety through procedural security • Welfare and practical needs of residents are important
Time 3	**Factor 3.1:** *Safety in the Environment*	• Need for safety within the environment • Public protection is not an objective • Need for routine, structure and consequences with clear boundaries • Safety through procedural security • Team express a curious approach to understanding behaviours • Team that can offer trust to the residents with support from each other • Welfare and practical needs of residents are important
	Factor 3.2: *Understanding Our Effects*	• Need for safety from harm and to feel safe to share thoughts and emotions • Public protection is a clear objective • Balance of procedural and relational security • Less need for routine, structure, expectations and consequences • There are clear interpersonal boundaries • Team is confident and has a more democratic approach • There is a clear Non-judgemental approach to understanding each other

9.2 Results: Correlation Analysis of the Expert Data and the Three Timepoints

The demographic data for the Expert Participants and the participants that make up each of the two Factors at each of the three timepoints can be found in Chapters Six, Seven and Eight.

To explore and therefore compare the Factors derived from the Q Analysis at each of the three timepoints with the Factors derived from the Analysis of the Experts, i.e. the 'Prototype', a Bivariate Correlation Analysis using the Z-scores for each Factor was undertaken using SPSS. Table 35 below details the Pearson Correlations found. Within Q Analysis, Z-scores (also called the normalised factor scores), represent a standardised method to measure how many Standard Deviations each statement in each factor array has been placed relative to the population mean. A Z-score can be placed on a normal distribution and is a method to compare results to a normal population. Z-scores are calculated as part of the routine Q Factor Analysis process using the KENQ Analysis software.

Table 35 below outlines the correlations between the three Factors derived from the Prototype and each of the two Factors found at Times One, Two and Three. The data for each of the Factors was normally distributed and a Pearson Correlation analysis was used. See Appendix 23 for the descriptive statistics).

Table 35. Pearson Correlations between the Z-Scores for each of the Factors (Expert and Approved Premise Staff Participants)

	EXPERT FA	EXPERT FB	EXPERT FC	Factor 1.1	Factor 1.2	Factor 2.1	Factor 2.2	Factor 3.1	Factor 3.2
EXPERT FA	1								
EXPERT FB	0.172	1							
EXPERT FC	0.106	**.442****	1						
Factor 1.1	-0.127	**.661****	**.599****	1					
Factor 1.2	0.244	**.520****	**0.278***	0.2	1				
Factor 2.1	-0.07	**.646****	0.251	**.608****	**.463****	1			
Factor 2.2	-0.227	**.468****	**.394****	**.711****	0.094	**.394****	1		
Factor 3.1	-0.126	**.530****	**.510****	**.816****	0.207	**.461****	**.785****	1	
Factor 3.2	0.083	**.635****	0.278	**.633****	**.506****	**.705****	**.453****	**.461****	1

NB: N= 50, (**) Pearson Correlation is significant at the p < 0.01 level (2-tailed) and (*) at the p < 0.05 level (2-tailed).

As can be seen from the correlation analyses, no significant associations were found between the Expert Factor A (The Safe Relating Space) and any of the Factors derived from the staff at the approved premises at each of the three timepoints. All of the associations found were very weak. This suggests that the collective viewpoints expressed within this Factor, i.e. a real value being placed in the meaning of the relationships, the sense of containment derived from this, in the interrelatedness to others and on inclusion and acceptance are not shared by the participants at either the beginning or after many months of engaging in the Enabling Environment process. The notions of relatedness to others, relational security and creating a sense of community with belonging and that is not problem focussed or orientated to risk management is integral to what the experts regard as an ideal Enabling Environment but is not found to be intrinsic to the essence of delivering such a social climate within an approved premise.

Surprisingly, there was no significant correlation found between Expert Factor A (The Safe Relating Space) and Factor 1.2 (Inclusion and Acceptance) given that there are a number of clear parallels between these two Factors qualitatively.

Contrarily, the analysis revealed significant moderate positive associations between the Expert Factor B (The Predictable System) and each of the Factors derived from the staff at the approved premises at each of the three timepoints aside from with Factor 2.2 (Safe Containment) which was a significant but weak association ($r(48) = .468$, $p < .01$). There were no definitive trends identified in the strength of these associations across time in either direction, suggesting the viewpoints that make up this Factor are inherent in the participants prior to when the Enabling Environment initiative begun, and remain characteristic throughout the Enabling Environment process.

The relationships found between Factor C (The Modelling Team) and each of the Factors derived from the three timepoints is less concrete. At Time One, the analysis revealed a significant and moderate positive association between the Expert Factor C and Factor 1.1 (The Predictable Environment), where $r(48) = .599$, $p = .01$; and a significant weak positive association with Factor 1.2 (Inclusion and Acceptance), where $r(48) = .278$, $P < .05$. Given that Time One was the baseline data, i.e. data collected prior to the Enabling Environment initiative, this suggests that these viewpoints also exist a priori within the staff at the approved premises.

At Time Two the analysis revealed a significant but weak positive association between the Expert Factor C (The Modelling Team) and Factor 2.2 (Safe Containment), where $r(48) = .394$, $P < .01$. This suggests some small similarities in how the staff implement a system that supports or interfaces with the need for meaningful interpersonal relationships to manage risk, likely to be accounted for by the relationships between those in the environment and the wider public, social and criminal justice framework. Similarly, at Time Three the analysis revealed a significant moderate positive

association between the Expert Factor C (The Modelling Team) and Factor 3.1 (Safety in the Environment), where r(48) = .510, P < .01 but not with Factor 3.2 (Understanding Our effects), where r(48) = .278, P > .05. This suggests that the shared viewpoints of the experts relating to creating boundaries, expectations and consequences for actions through a pro-social model delivered by the staff team is found within the viewpoints of the participants at the approved premises at this time point, but only to a moderate degree as these views are represented by the associations in only one of the two Factors.

9.3 Discussion of the Findings

9.3.1 Overview

The aims of this Study (Study Two Part B) are to explore and compare these separate analyses as a connected time series to explore the qualitative differences in the viewpoints expressed towards the approved premise environments over time. With this, what is helpful to first identify is the relationship between the Expert Factors and Time One, i.e. the viewpoints at the approved premises prior to the Enabling Environment process beginning. This will help to more clearly define what has changed across time within the approved premises.

9.3.2 The Relationship Between the Expert Viewpoints and Time One (Baseline)

It is suggested that the collective viewpoints comprising the two Factors at Time One are intrinsic to the perspectives of the staff working within the approved premises as they exist prior to and independently of any active engagement with the Enabling Environment process. Across these two Factors there is some balance present between routine, structure and boundaries and allowing

trust through a sense of community, belonging and social inclusion; between the provision of physical safety and the safety to share thoughts and emotions; the use of teamwork to develop and implement the safe environment whilst also modelling democratic and pro-social relating; and between a prescriptive approach with public protection as an agenda and openness and collaboration between staff and residents. These are important aspects given that both the perceived experience of the atmosphere and the structure or framework of a therapeutic environment can be amongst the most important factors of the experience of those receiving it (e.g. Beech & Hamilton-Giachritis, 2005; Middelboe et al., 2001; Stickley & Hui, 2012; Rossberg & Friis, 2004a).

At this baseline timepoint, the comparison is between the staff prior to the Enabling Environment process and those clinicians defining an ideal Enabling Environment. Given this, it was found that there is no meaningful association with the viewpoints of Expert Factor A (The Safe Relating Space), i.e. where real value is placed in the meaning of the relationships, in the importance of community, on emotional containment, on the interrelatedness to others and on inclusion and acceptance shared by the participants. Although the strongest relationship with the Factor 'The Safe Relating Space' was with the Factor 1.2, i.e. 'Inclusion and Acceptance', this is non-significant. This is a surprising finding given the closer qualitative similarities between these two Factors. What may be present in the findings here is not that the safety to share experiences and relating interpersonally is absent in this Factor, but that the viewpoints expressed in Factor 1.2 reflect a more aspirational notion of this and are not yet fully formed by the staff as they have not yet been immersed in the Enabling Environment process. Although the staff at the approved premises had not yet received any formal training in or exposure to engaging in the Enabling Environment process, there was a generic understanding that these principles are underpinned by a greater openness in including others and relating to each other. Similarly, it may be the case that Factor 1.2, although is underpinned by the value in interpersonal relationships and shared communication (i.e. relational

security), the notions of containment (Aiyegbusi, 2004b), i.e. the curious understanding and reflecting of distressing experiences through the relationships is not as clear and present.

What can be derived from the relationships with the Expert viewpoints at this timepoint with more certainty is that the mainstream functioning of an approved premise is about the provision of a safe, team delivered structured space where social inclusion and acceptance within the community, supported by pro-social modelling is sufficient to effectively meet the objectives of the environment, i.e. reducing risk, protecting the public from reoffending and helping individuals reintegrate with support back into the community (e.g. Joseph & Benefield, 2012; Turley et al., 2013). This is indicated by the clear presence of the Expert Factor B (The Predictable System) being meaningfully associated with both of the Factors at this timepoint. These viewpoints are suggested to represent an intrinsic function and purpose of the approved premise. Given that these approved premises firmly exist within a criminal justice framework and are component parts of the National Probation Service, it is not unsurprising that these viewpoints are prominent. For example, Marshall and Adams (2018) identify two salient themes that encourage therapeutic relationships to develop, and which help to moderate any difficulties experienced in balancing safety and a therapeutic approach. In particular, these include an honest, open and respectful perspective and the importance of meaningful social processes when relating to others and communicating. Within the Expert Factor B, these are prevalent in the overarching principles of a need for structure, routine and expectations on what is required in the environment and of individuals within the environment. This is supported by a clear understanding of interpersonal boundaries, being able to offer support predictably and being inclusive and valuing those within the environment.

What is further evident at this baseline timepoint is that there is a meaningful relationship between Factors 1.1 and 1.2 and the Expert Factor C (The Modelling Team), defined by a balance between procedural and relational security (Appleby, 2010; Reed, 1994), and creating safety through an

experience of community and an effective team modelling pro- social and professional relationships. There is a much stronger association with Factor 1.1 (The Predictable Environment) than with Factor 1.2 (Inclusion and Acceptance). This indicates that what is present at Time One and also essential to an approved premise environment is a system within the environment that offers a scaffolding to support how the staff and residents interact to balance the need for meaningful interpersonal relationships and to manage risk. Furthermore, this is suggested to be a team based pro-social modelling approach which allows the staff to support the residents to live adaptively in the wider public community by exposing them to a smaller pro-social community. This is consistent with the need for any therapeutic environment to try to recreate the roles of an individual's social relationships within such an environment with the wider social structure (Schoenholtz-Read, 2001), as well as how that system itself exists within a wider social structure (Knobloch & Knobloch, 1979).

Furthermore, given both Factors at Time One also involve public protection as a core element, the balance of the viewpoints at this time point are supportive of the view that approved premises offer both public protection and meaningfully engaging and relating to individuals to reduce the risk of further offending (Cherry & Cheston, 2006). This is in observance of the value held in a socially empowered culture (Turley et al., 2013) that is faithful to a core wider public, social and criminal justice framework (Trotter, 2009; Turley et al., 2011).

9.3.3 The Relevance of the Expert Viewpoints Across Time

From the analysis of the participant viewpoints across time there are a number of distinct similarities that exist, and that remain consistent with those represented in the Factors at Time One. It is therefore prudent to first explore these. Firstly, looking at the correlations with the Expert

viewpoints there remains no relationship between Expert Factor A (The Safe Relating Space) across the subsequent two timepoints. This suggests that the viewpoints expressed in this Factor are not regarded as being intrinsic to the function and purpose of an approved premise and are not concepts that engagement with the Enabling Environment process has influenced. Potential reasons for this may be that this Factor represents the viewpoints of those not working within approved premises and are more representative of elements consistent with a formalised therapeutic community (e.g. Gill, 1967; Middelboe et al., 2001) rather than of an approved premise. A therapeutic community, as a process of interpersonal relationships is considered a treatment modality (Thomas et al., 2002; Solomon-Mazzanti, 2000), however what is evident from these findings is that an Enabling Environment is not considered to be a treatment intervention in itself as is suggested by Johnson and Haigh (2011). The focus of the network of interpersonal relationships as a mechanism for change (Middelboe et al., 2001) is not regarded as being fully possible within an approved premise, although from the qualitative findings (particularly in Factors 1.2 and 3.2) it is suggested that an Enabling Environment does represent a social culture or milieu consistent with that defined by Bolger and Turner (2013).

Although developing and focussing on relationships are integral in social learning and psychological change (Almond, 1975) and in Enabling Environments (Haigh et al., 2012), this is not present explicitly in the findings. This is possibly because the resident population is highly transient. The average length of stay in an approved premise is three months and an individual's plans for moving on must be made at the same time as the individual is referred to the approved premise (NOMS, 2014). This is inconsistent with an individual being able to meaningfully connect with a culture that is focussed upon developing and maintaining interpersonal relationships as a means for managing risk because it is organic in nature and needs consistency in the interrelationships between staff and residents to develop this. As the provision of a safe environment from threat for both staff and residents is a foundational element of most of the Factors across the three timepoints, a reliance

on this notion of relational security as a means to achieve this safety is not perhaps fully possible. This is despite this type of security being regarded as most important in any therapeutic process and being fundamental to the holistic security in such an environment (Reed, 1997). Furthermore, these aspects sit outside what is regarded as the core functions of an approved premise, i.e. the provision of safe accommodation, support with lifestyle and associates, helping individuals to understand their thinking and behaviour, manage their relationships and address alcohol and drugs difficulties (HMIP, 2017).

What is also evident across all three timepoints is the meaningful positive association with the viewpoints of Expert Factor B (The Predictable System). Particularly, this Factor emphasises managing an environment safe from threat and harm for both staff and residents through the provision of procedural security, structure and routine, with an emphasis towards a community approach, involvement and collaboration between residents. There is also the presence of clear professional and interpersonal boundaries, staff being predictably available and valuing the contributions of those within the environment. The evidence of this Factor being present across time indicates that it represents a shared perspective that is inherent in the function of the approved premise environment, and independent to the Enabling Environment process. There is an emphasis throughout these three timepoints on the provision of a social structure with clear expectations of behaviour which is supported by the way that staff relate to and engage with the residents of the approved premise. This is regarded as being indispensable in psychosocial interventions such as an Enabling Environment (Beutler et al., 2000). Furthermore, these perspectives underpin the provision of a safe environment and they encourage meaningful relationships and interactions, all of which are consistent with previous findings on therapeutic milieu (Davidson et al., 2005; Nijdam-Jones et al., 2015).

These aspects are also consistent with several Enabling Environment principles, especially the emphasis on functional interactions being imperative with the need for boundaries to be consistent and a shared understanding of attitudes and behaviours being expected and understood (Cherry & Cheston, 2006). Similarly, although there are many interrelated factors necessary for a safe space and the reduction of aggression (Trestman, 2017), a structure to the environment as is evident in this Factor has been found to be helpful in stabilising difficult and challenging patients presenting with confrontational behaviour (Bos et al., 2012). This is an important finding across the timepoints because these approved premises exist within a public protection framework (Joseph & Benefield, 2012; Turley, Payne & Webster, 2013) and the attitudes and approaches of staff to those in the environment are a primary contributor to affecting a positive and safe climate (Stickley & Hui, 2012).

What is less consistent in the findings is the relationship between Expert Factor C (The Modelling Team) and the second and third timepoints. Within Time One it is suggested that providing an environment-specific pro-social model helps as a framework to bind together the need for meaningful interpersonal relationships with managing risk. At Time Two there is only a weak association between this Factor and Factor 2.2 (Safe Containment), which qualitatively has very little overlap given pro-social modelling is not a clearly defined perspective across this or Factor 2.1. It is therefore likely that the weak association found at Time Two reflects the presence of similarities unrelated to the core narrative of the Expert Factor C (e.g. Factors 2.1 and 2.2 both reflecting less structure, routine or consequences needed and the need to provide safety from threat); and not the presence of a clear system-wide framework necessary to apply the balance risk and relationships (Marshall & Adams, 2018).

There are also two pertinent contexts present at Time Two. Firstly, the limited time the participants have been engaged with the Enabling Environment process given it is an organisational change; and

secondly the presence of resource difficulties and real threat of harm from residents. It is therefore suggested that at Time Two there are no specific or robust mechanisms established by the staff team, or indeed a sense of safety present in the staff to manage the difficulties encountered. The staff are attempting to maintain a safe environment by either being providers to the residents (Green, 2018) struggling with professional boundaries; or by establishing safety mechanisms and containment (Dallos & Draper, 2010; Foster, 2001; Haigh, 2012) to manage the pervasive resource difficulties and incidents of violence. Both strategies are inconsistent with the literature relating to pro-social modelling (Trotter, 2009; 2010), to a shared culture of enquiry (Kennard, 2004; Main, 1989) or to the focus on the needs of residents and how to be responsive to these in the environment (Cherry & Cheston, 2006; Latessa & Lowenkamp, 2002). It is safer to return to a more commonly understood default option with practices orientated to public protection (D'Aunno et al., 1991).

Although the notion of pro-social modelling is not explicitly expressed within either Factors 3.1 or 3.2, there is a meaningful correlation between Expert Factor C and Factor 3.1 (Safety in the Environment). This suggests that in addition to the shared perspectives that are likely inherent in the function of the approved premise independent to the Enabling Environment process, a pro-socially modelled team approach as defined by this Factor has sustained some presence across time. Within Factors 3.1 and 3.2 there are fewer viewpoints linked towards fire-fighting and primarily containing threat, and there has been a longer time engaged with and exposed to the Enabling Environment process with more time to understand any resistance, manage uncertainty about the change (Coulson-Thomas, 2009; Shaw, 2002). There has also been time to establish a schematic (Davies et al., 2019) to an enabling culture. There is also a re-emergence of an identification with relational security as well as procedural security, and the staff teams are beginning to take a curious and more psychologically informed understanding of the consequences and impacts of behaviour on others as is consistent with healthy social relating (Joseph & Benefield,

2012; Turley, Payne & Webster, 2013) as well as akin to the beginnings of the concept of containment (Adshead, 1998; Aiyegbusi. 2004b). Particularly, being non-judgemental (Gildberg et al., 2012; McCallum et al., 2016) and developing trust (Askola et al., 2017; Cleary, 2003) are the principles that the staff are beginning to work from to relate to each other instead of the previous adherence to rules, process and managing risk. This greater focus in thinking about interpersonal relationships, safety to relate to others and a greater investment in a democratic social therapeutic process is a positive shift towards a process where relationships are of importance (Schofield & Williams, 2015), and of a understanding the function and nature of the psychological relationships in such environments (Brown, 2014). However, it is evident that the staff are only beginning to be able to think about this in regard to explicit behavioural impacts as opposed to implicitly understanding and communicating their understanding of the resident's internal emotional worlds.

9.3.4 Qualitative Interpretations of the Staff Perspectives Across Time

There are two Factors identified at each of the three timepoints, and across these six Factors there are two predominant qualitative themes that exist across time. These are differentiated by subtle nuances that are important to both the context of the approved premises at the differing timepoints and in how we understand their identification within the Enabling Environment process.

Given that there is a limited empirical evidence base for understanding relationships within approved premises or Enabling Environments (Davies & O'Meara, 2018) as forensic settings, it is helpful to draw upon literature relating to other forensic healthcare settings to help understand these two themes. Both themes identified through this study parallel those identified by Gildberg et al. (2010), i.e. (1) paternalistic and behaviour changing care approaches; and (2) relational and personal quality approaches. The first theme mirrors the notions of procedural security (Reed,

1994; 1997), and is the need to create an environment safe from physical threat, led by a staff-focussed directive approach through strong boundaries, clear expectations for behaviour and overt consequences for inappropriate actions, with an underlying onus towards public protection. This is also consistent with paternalistic and behaviour changing care approaches defined by Gildberg et al. (2010). This incorporates control, rules, structure and parenting-type behaviours as the means to manage safety from threat through controlling and observing, setting limits and enforcing rules, and supporting patients practically. As in evident in this theme, the residents are regarded as having difficulties managing boundaries and relationships and the staff have the responsibility to hold this need to manage conflict (Hinsby & Baker, 2004). Similarly, the structure, rules and limits are set by the staff, and are maintained through the clear professional and interpersonal boundaries (Hinsby & Baker, 2004; Rask & Alberg, 2002). These notions can be found at the core of Factor 1.1 (The Predictable Environment), Factor 2.2 (Safe Containment) and Factor 3.1 (Safety in the Environment). As can be seen by Table 35 and Figure 2 above, there are closer associations between each of these Factors, all of which share very similar constructs, and are essentially the same.

There are however small important differences found at Time Two, particularly in the way that the staff create the safe environment and protect against threat (Gildberg et al., 2010; Hinsby & Baker, 2004). As previously identified, in the months leading up to the second time point there were marked staff resourcing difficulties and incidents of violence in the approved premises that resulted in a division in the way that the staff responded to this. This is typified in Factor 2.2 where the strategy to maintain predictability and safety is to focus more rigidly on rules, boundaries and managing problematic behaviours through a lowered tolerance to threat and enacting consequences to difficult behaviours (Hinsby & Baker, 2004; Meehan, McIntosh & Bergen, 2006). The viewpoints in this Factor are more reactionary and disciplinary and there is a strong reliance on procedural security and organisational containment (Ruch, 2005). These tendencies have been defined in the research literature as being common when there is a need to maintain control over

the threat of difficult interactions especially by imposing limits and in the enforcement of rules (Clarke, 1996; Bowring-Lossock, 2006; Alexander & Bowers, 2004).

Similarly, although Factor 2.1 serves the same function of preserving safety from threat and unpredictability, there is a functional difference in how this is achieved. It is suggested that these viewpoints indicate that the difficulties experienced have impacted the understanding and implementation of boundaries, and as such staff are not able to rely on structure, routine and consequences to maintain a predictably safe environment. There is an acquiescent, placating and yielding to the resident's, especially their practical needs (Hamilton, 2010; Van der Helm et al., 2011) as a systemic strategy to ensure they are safe from threat and conflict and to avoid future interpersonal conflict (Green, 2018). The staff also provide for the resident's practical needs more unconditionally, consistent with previous findings (Cleary, 2003; Gildberg et al., 2013), and it is evident that staff limit autonomy and independent decision making to reinforce this. The two reactions to the difficulties experienced and what accounts for the differences at Time Two could potentially be the division in the perspectives of the residents in how best to manage their behaviours (Gabbard, 1989; Bland & Rossen, 2005). Similarly, given the operational complexities within forensic settings (Marshall & Olphert, 2008) and that an integrated framework for understanding organisational change does not exist (Beer & Nohria, 2000), the responses could be reactive to the organisational change being enacted within the approved premises (Davies et al., 2019; Coulson-Thomas, 2009; Shaw, 2002; Ward et al., 2003).

Also, although Factor 3.1 at the third time point is practically identical to Factor 1.1 at the baseline, the difference is that staff focus more internally on understanding the interactions within the environment and have less onus on public protection. The staff are also able to better trust their judgements and are beginning to take a more curious approach to understanding the behaviours of residents. This is suggested to demonstrate a greater reliance on using a set of principles for

relating to and understanding the resident's behaviours (Martin & Daffern, 2006) rather than a previous reliance on structure and rules to work from. It is suggested that this is a positive shift in the way that the staff maintain safety from threat and is more consistent with a meaningful social and therapeutic milieu (Bolger & Turner, 2013; Brown, 2014). It however remains unclear whether these viewpoints at this time point can be attributed to an identification with the Enabling Environment process, or whether it represents a return to previously embedded processes in the approved premise found in Factors 1.2 (Inclusion and Acceptance) and 3.2 (Understanding Our Effects).

The second theme reflects notions of relational security (Appleby, 2010) and is the aspiration to provide an environment where staff and residents are safe to relate to each other, to share their emotions and experiences and where the impacts on others are considered more thoughtfully. This is through a more democratic approach by the staff who can rely on principles in how to relate to others rather than reliance on imposed rules and structure. This is consistent with relational and personal quality approaches identified by Gildberg et al. (2010). This is underpinned by the meaning given to and value placed on interpersonal relationships as the fabric of the relational approach and is characterised by personal qualities offered by the staff, engagement and support with social activities. As in evident in this theme, the staff offer more thoughtfulness and awareness of the impacts on the residents, they offer more flexibility in trust and a more genuine approach, all of which have been found to be supportive of meaningful therapeutic relationships (Brunt & Rask, 2013; Rask, Brunt, & Fridlund, 2008; Schafer & Peternelj-Taylor, 2003). These notions can be found within Factors 1.2 (Inclusion and Acceptance) and 3.2 (Understanding Our Effects). As can be seen by Table 35 and Figure 2 above, there are closer links between both Factors. Qualitatively, these include the stronger presence of a reliance on relational security and not procedural security, clear boundaries but less need for clear expectations for behaviour and overt consequences for inappropriate actions, and a more inclusive and shared approach to engaging the residents. There

also continues to be an underlying orientation towards managing risk and public protection which is inherent to such environments existing within the criminal justice framework (Kennedy, 2002; NHS, 2014).

Factor 3.2 differs to Factor 1.2 principally in the extent to which the resident's emotional experiences are considered and potentially impacted by others. As noted above, Factor 1.2 is underpinned by more open collaboration and shared feedback, active acceptance and inclusion of others in the shared goals. Trusting connections are made possible through fostering a greater shared sense of belonging and community culture which indicates a wider consideration and understanding of the emotional impacts on individuals within the wider community. The focus being on both individuals and their interrelationship with the shared community suggests a greater degree of thoughtfulness of others' feelings and the system identifying more prominently with relational security. Factor 3.2 in comparison is different by the presence of both relational and procedural security in roughly equal measures, and although there is less reliance on structure and rules to manage safety, there is a clear focus on maintaining an environment safe from physical threat. Furthermore, this Factor is defined by the strong presence of taking a non-judgemental approach to interactions, which although this presupposes a greater degree of equality, acceptance and thoughtfulness of others (Bowring-Lossock, 2006), in this Factor this does not extend to the recognition of their emotional experiences or wider internal emotional worlds. Therefore, although the viewpoints expressed are more consistent with healthy relational security, they do not yet reflect the notions inherent in relational security that surround the containing experience, i.e. that which is derived from the staff's ability to genuinely and authentically engage the person who is in distress. There is the understanding that in the environment, action A has a consequence of B, but not what this means more explicitly to the individuals (Gildberg et al., 2013). For example, this can be likened to an analogy of a 'pinball machine' where we recognise that the movement of the spring

and paddles has a direct causal effect on the ball, but without having any control over the direction, speed or distance that the ball travels in.

Notwithstanding, the presence of this at the third timepoint is positive and is suggested to reflect some meaningful ability to think about relationships within the environment to problem solve, relate to others and manage risk. It is suggested that the staff teams are beginning to repair from the difficulties experienced at the second point of data collection (Time Two) and they are working towards a balance between custodial and relational expectations (Castledine, 2016; Appleby, 2010; Hammer, 2000; Martin & Street, 2003). It is suggested that a process of reflective or experiential learning (Atkins & Murphy, 1993; Kolb, 1984) has occurred between Times two and Three, particularly in how the staff relate interpersonally with the residents. The process of reflective or experiential learning is suggested to be a process of "learning through and from experience towards gaining new insights of self and practice" (Finlay, 2008, p. 1). This is suggested to take the form of three sequential stages whereby staff identify discomfort in how they are acting towards residents, they reflect and critically appraise their behaviour and they begin to develop a new and more functional perspective (Atkins & Murphy, 1993). Specifically, it is suggested that the staff have identified that the means by which they related to and engaged with the residents at Time Two is unhelpful, and they have evaluated their own responses to their behaviours and gained new insights into how to best support and engage the residents. This is evidenced by the real shift away from the either the acquiescent or controlling polarity found at Time two to a more genuine way of relating and understanding the relationships with the residents at Time Three. There is also a more defined shift back towards the manner in which they engaged with the residents at Time One, i.e. prior to the resource and behavioural difficulties they experienced.

This increased focus on relationships and the value in having these relationships is a conceptual shift in the viewpoints since Time Two and does reflect an ability for the staff team to be more

thoughtful about understanding and managing difficult interpersonal behaviours instead of being reliant upon rules and consequences (Howells & Day, 2007; Turley et al., 2013; Van Kessel & Van der Linden, 1991). Similarly, this relational problem solving is also consistent with the notion of mature coping, i.e. where staff are more able to recognise the salient problems, work through these without reactive responses and develop a community where support and empathy are present (Johnson, 2002).

Chapter Ten:
Conclusions

10. Overall Conclusions

Enabling Environments are identified as being social processes where the quality of relationships is thought to enhance personal growth, social learning and change (Haigh et al., 2012) and are environments that harnesses the therapeutic value of relationships between people (Schofield & Williams, 2015). Study One aimed to develop an understanding of what represents an ideal Enabling Environment as defined by experts in the field. By analysing the Q-Sorts of the experts, three Factors were identified that represent how experts in the field view an ideal Enabling Environment. These were (Factor A) '*The Safe Relating Space'*, (Factor B) '*The Predictable System'* and (Factor C) '*The Modelling Team'*. These findings help us to understand what is regarded as being essential in an Enabling Environment but are not necessarily what is effective or possible in actual clinical practice within the approved premises in this study. What is important to derive from this Study is that an ideal Enabling Environment requires three core components. These are (A) an interpersonal culture based upon social and relational foundations; (B) a systemic structure and framework of how this can be implemented and maintained meaningfully through clear processes; and (C) a practical model to use to actualise these that is understood by all and is consistent with the objectives of both the environment and the wider social system.

Study Two (Part A) had two broad Phases. Firstly, to explore the meaning and significance of how the staff make sense of the approved premise environments before the Enabling Environment initiative commenced. The analysis of the Q-Sorts from Time One (baseline) yielded two meaningful interpretations of these approved premises with a need for '*The Predictable Environment'* and the presence of '*Inclusion and Acceptance'* as the fundamental themes. These are suggested to be the

core tenants of how staff experience and understand their environment prior to any engagement in the Enabling Environment initiative. Importantly, what is evident in this study is that the approved premises appear to be functioning well with clear processes and structures in place to manage risk and public protection and safety from threat, as well as providing a working model of how to relate to and engage residents that achieves the objectives set out for them as approved premises (Cherry & Cheston, 2006; HM Inspectorate, 2017). This is supported by the associations with two out of the three Expert Factors, i.e. (Factor B) '*The Predictable System'* and (Factor C) '*The Modelling Team*'. There are also qualitative similarities with Expert Factor A (*The Safe Relating Space*) but no statistical relationship was found. Given this relationship is not present throughout the study, it is suggested that this is because it is neither possible due to the transient and high-risk resident groups involved nor is it a functional objective of an approved premise to create a treatment culture *proper* where relationships are used as an agent of therapeutic change. Similarly, given the notion of containment is inherent to relational security within this Factor, it is possible that the short-term relationships between staff and residents do not allow for this to authentically develop. It is suggested that approved premises achieve an effective service when they can provide residents who have complex needs and violent histories with a place where they can feel safe, included, where there are boundaries and expectations, and where they are supported in transitioning back into the community after a period in custody.

The second Phase of Study Two (Part A) investigated the viewpoints of the staff within the three approved premises as they were engaged in implementing the Enabling Environment initiative over a 12-18-month period. This was to explore what the staff understand to be important within their environments and to understand the subjective experiences of what forms the culture and therapeutic milieu of that environment across time. Given the evident paucity of research literature relating to approved premises, particularly with regard to Enabling Environments in this setting, this Study identified a number of important systemic responses in the staff group to the challenges that

were experiencing. Although it is not possible to fully discern how the experience of organisational change or the staffing resource difficulties contributed to the marked difference in viewpoints at the second time point, what is evident is that the systemic reactions to the violent incidents that occurred are consistent with findings from other forensic and healthcare setting. Particularly, there is a division in the responses, where staff either subsume to a placating and acquiescent style (De Dreu & Weingart, 2003; Hamilton, 2010; Van der Helm et al., 2011; Van der Helm & Stams, 2012) or become problem-focussed, over-controlling and dominating (Hamilton, 2010) to manage the threat of harm and to attempt to maintain social control within the environment. What is apparent at this timepoint in response to the difficulties is that nearly all viewpoints orientated towards meaningful relating to the residents is lost. This indicates a significant element of stress within the staff as a group and may suggest that the staff are actively avoiding conflict and may have lost confidence in their ability to use their practical model of relating (i.e. pro-social modelling) to manage any threat through meaningfully understanding the residents', thoughts emotions and behaviours. Of note, Bos et al. (2012) found that a stricter and more highly structured treatment environment has been found to be helpful in stabilising difficult and challenging patients presenting with confrontational behaviour.

At the third timepoint the viewpoints are beginning to return to those analogous to the Enabling Environment principles, and to those identified within Factor 1.2. This lends further support to the perspectives at Time Two being more situational and context specific, and that the staff have engaged in a process of reflective and experiential learning (Atkins and Murphy (1993; Kolb, 1984). What remained in the viewpoints at Time Three was the need for structure and process inherent in the Expert Factor B, alongside recognition of relational security with a greater confidence to use a model to provide supportive and understanding relationships with the residents that has been found to be consistent with increased well-being (Brunt & Rask, 2005; Nijdam-Jones et al., 2015). It is suggested that the staff at this final time point are becoming more effective at managing the dual

roles they have when simultaneously offering a therapeutic and risk management framework (Marshall & Adams, 2018).

Study Two (Part B) explored how the staff's perspectives of the Enabling Environment culture changed over time with more exposure to the Enabling Environment culture. The objective was to explore whether staff shifted in their views of their Enabling Environment as they progress through the process. Through the quantitative and qualitative interpretation across time it was found that although there were differing viewpoints over time, there were few real changes in the viewpoints found in this study between Time One and Time Three. The broad expectations of an Enabling Environment are that the ten core standards are embedded in the way that the environment is structured and how the relationships are fostered and promoted. These ten standards include Belonging, Boundaries, Communication, Development, Involvement, Safety, Structure, Empowerment, Leadership and Openness. The results indicate that more of these aspects were present in the shared perspectives of the staff at Time One than at Time Three. This was predominantly because the main perspectives expressed at Time Three surrounded Factor 3.1 *Safety in the Environment* which replicated those expressed in Factor 1.1 *The predictable Environment* at Time One. Furthermore, it is suggested that the collective viewpoints across both Factors expressed at Time One are more coaligned with an Enabling Environment than those expressed at Time Three. This is because Factor 3.2 lacks the elements of transparent inclusion and acceptance of the residents, there is less collaboration and openness to share their emotions, and less importance is placed on the experience of a shared community within the approved premises. All of these are core to both a therapeutic environment (Haigh, 2013) and an Enabling Environment (RCP, 2010), and are found in the viewpoints of Factor 1.2. Additionally, it is evident that there are stronger associations between the Expert viewpoints and the viewpoints of the staff at Time One than at any other timepoint, suggesting that there was no progressive identification with the Enabling Environment culture found over time. Therefore, although one of the approved premises

had achieved the Enabling Environment Award by Time Three, the staff views were not found to be more aligned with the Enabling Environment culture as defined by the Experts in this Study the closer the approved premises were to being awarded the Enabling Environment status.

Given the findings indicating that there were few meaningful changes towards the Enabling Environment milieu over time and there was a notable loss of relating to the residents at Time Two, there are important implications to identify. Firstly, as previously noted by Davies et al. (2019) leadership and functional support from the organisation is imperative in supporting staff through developing such an organisational and therapeutic change in culture. This needs to be grounded in a relational perspective (i.e. a leader being a 'culture carrier') and from a training needs / professional development perspective (i.e. providing training, reflective support and supervision). Peer support, training, supervision and reflective learning forums are essential to moderate any negative or unhealthy patterns of relating to the residents as identified in Time Two. Secondly, operational considerations need to be made by senior managers for what is thought to be (1) necessary (e.g. a pro-social framework and an environment with boundaries, consistency and clear expectations to provide safety from threat and safety to share emotions); and (2) preferred (e.g. relating to residents in an accepting, inclusive and psychologically curious manner) in an approved premise that upholds the Enabling Environment principles.

Notwithstanding, this is not to explicitly state that engaging in the Enabling Environment process did not have a meaningful impact on the staff throughout this Study. Given there is little empirical evidence yet for the effectiveness of Enabling Environments (Davies & O'Meara, 2018) and there were marked complications encountered by the staff which also resulted in data collection difficulties, further time is needed to explore how the staff viewpoints might change with additional engagement with the Enabling Environment process. The findings suggest that between Time Two and Time Three the staff demonstrated some positive ability in their capacity to repair from the

difficulties they experienced and develop a greater awareness of the balance between therapeutic and risk management roles and functions. This may have been as a result of the structure and process of the Enabling Environment ethos supported by their ability to engage in experiential learning. This is evidenced through their ability to move away from a rigid reliance on structure and rules, to offering a greater degree of equality, acceptance and thoughtfulness of the residents and in them beginning to engage interpersonally with the residents to support them with their needs. This is pertinent given that a culture such as an Enabling Environment can be regarded as an organism that is dynamic and requires meaningful relationships between the staff and residents to develop (Kirby & Cross, 2002).

10.1 Links to Clinical Practice

In thinking how these findings directly link to clinical practice, the relationship between the Expert Factors and the Factors derived at the three timepoints help us to recognise that having a predictable system where residents can feel safe, contained, included and valued with the presence of routine and boundaries is fundamental to an approved premise *per se*, and one that is engaging in the Enabling Environment process. Past research has found that that the most salient aspects to social treatment fall within the *in vivo* social interactions between individuals and their day-to-day interactions and relationships (Shine, 2010). Here, it is suggested that the ability for approved premises to offer such an environment to the residents is a functional and effective way of supporting the complex resident group through their transition into the community over a relatively short period of time.

Moreover, the notions of relatedness to others, relational security and creating a sense of community with belonging and that is not problem focussed or orientated to risk management is

not intrinsic to the essence of delivering such a social climate within an approved premise. This finding is important going forward as it is essential to think about what is pertinent to focus upon in such environments. It is potentially the case that creating a true safe relating space governed by relational security within an approved premise is not achievable or is too ambitious because it places the onus of responsibility in the maintenance of the therapeutic and social environment upon staff in a repeating motion. This means it is likely to be susceptible to external limitations such as staffing dilemmas, funding resources or difficult residents which past studies have found results in a regression to structure, process and procedural security (Hamilton, 2010). An exacerbating factor is that the resident population is highly transient, where the average length of stay is three months (NOMS, 2014). This inhibits the ability for this type of relational process to function effectively because it is organic in nature and needs consistency in the interrelationships between staff and residents to develop. This is suggested to be especially difficult to create when working with individuals with complex needs and who are a high risk for violence (Joseph & Benefield, 2012; Turley et al., 2013).

Owing to the system responses observed in relation to the difficulties leading up to the second point of data collection and given that the quality of the therapeutic relationship is thought to be related to the degree of self-reflection and self-awareness by the staff offering and maintaining the therapeutic environment (Eliassen et al., 2016), it is imperative that staff receive appropriate training regarding this. For example, Nesset et al. (2009) found that meaningful changes in the therapeutic climate and treatment milieu of a secure forensic psychiatric hospital environment were achieved by a short training programme about milieu therapy. Importantly then, if the approved premises are to maintain engagement in this social and therapeutic milieu, training is required in developing an awareness of custodial Vs relational care and support (Gildberg et al., 2013), how to balance these dual roles (Marshall & Adams, 2018) and a greater understanding on managing personal and professional boundaries during the experience of threat (Hamilton, 2010).

Similarly, it has been found that when feeling unsafe the staff teams have shifted in their boundaries and reacted to their feelings towards the residents. The process of reflecting on clinical experiences is well established in the therapeutic literature (Atkins & Murphy, 1993; Schon, 1983), especially the need to reflect on one's own thoughts and behaviours, the need to relate this to the ideas and practices of others and to incorporate these within wider professional practice (Wildig & Cushway, 2007). It is therefore essential that staff, both collectively and individually are offered suitable clinical supervision and reflective practice to safely support them to develop and engage with such a therapeutic environment.

Finally, because the Enabling Environment initiative is regarded as a process of organisational change (Davies et al., 2019) this will likely have led to a lack of understanding and uncertainty about this change (Coulson-Thomas, 2009; Shaw, 2002) and resistance to it (Bovey & Hede, 2001). This is important as approved premises undertake a complex and multifaceted function within a criminal justice framework. Training and support in understanding change, especially the systemic and individual responses to this would be helpful, as would more explicit training and support about Enabling Environments. Similarly, strong and direct Leadership could be one way that this process is supported given that it has been found that if there is an increase in psychological working without positive support and leadership, studies have found that staff can experience alienation, feelings of wishing to disengage and feeling stuck in their practice which can result in increased vulnerability to stress and burnout (Scanlon & Adlam, 2012).

10.2 Limitations to the Study

In relation to the overall research design, the original research proposal included investigating the experiences of both staff (via Q Methodology) and residents (via Interpretative Phenomenological

Analysis) of the approved premises. This is evident on the Ethics Applications / Approval documents as well as on the Consent Form and Information Sheets. However, (1) due to experiencing time limitations in undertaking this research project as a result of researcher access difficulties to the approved premises; and (2) the nature, content and volume of data collected through the Q Methodology studies, the second planned aspect of the research did not take place (i.e. the IPA study). This is a key limitation because it may have added an additional texture and understanding of the Enabling Environment process from the lived experiences of the residents. This could have been compared to the viewpoints interpreted from the Q studies.

With regard to the methodology, this research uses a Q Methodology, a process whereby statistical and theoretical methods of generating and analysing data are undertaken that involve both quantitative and qualitative principles. There is as such a discord in the expectations from what could be achieved with the data obtained and analysis procedures, and it is uncommon to use Q Methodology in a longitudinal study design, although empirical precedence has been set. Given that Q Methodology is not designed to generalise the findings more widely from the results, all that can be said from this study is related to the participants in these particular approved premises. It is pertinent to ask the question at this stage as to whether Q Methodology is a research design that has sufficient specificity and sensitivity to explore changing perspectives towards such a complex and multifaceted concept such a therapeutic culture or climate.

The results of this study also cannot be fully generalised because of a number of methodological limitations. Firstly, because of a possible risk of bias (Cross, 2005), there are subjective influences by the researcher on the sources and interpretation of the material used in the general Concourse; and secondly, there will be a researcher influence on both the selection of the final statements used in the card sorts and in the interpretation of the factor arrays. It is possible that other options and different opinions exist and were not included in the Concourse. However, a rigorous and

systematic approach was used when identifying the relevant literature in the Concourse and it also included focus groups with key individuals in the field. A diligent process was applied to ensure that a full range of perspectives, viewpoints and empirical evidence was represented in the statements, and that less prevalent notions were able to be considered. Similarly, rigour was applied when sourcing and sampling the statements and regular consultation was sought with an academic and clinical supervisor throughout the process. Overall, this study cannot claim to have identified all the viewpoints held by either the experts in the field around Enabling Environments or in regard to the staff perspectives towards their environments, but the viewpoints found appear to represent the diversity in the theory and practice of developing and working within social and therapeutic cultures.

One key limitation in the study was the number of participants that took part in Study Two (Part A). Essentially, there were fewer participants than were first anticipated. This was for two reasons. Firstly, because staffing resources and retention difficulties were experienced across the three approved premises; and secondly once the E3 organisational change had been implemented there was a formal change in the staffing structures being initiated in the approved premises. This meant that the approved premises were staffed on fewer individuals per shift rotation. It was not possible to seek out further participants within the research as it used a purposive and representative sample of the staff working within those approved premises at the time of the data collection. However, because Q Methodology does not require a large number of participants to obtain significant data for the purpose of identifying and interpreting perspectives, it is suggested that the goals of the study were achieved.

Due to the low participant numbers the data from the three different approved premises were combined and analysed together. No analyses were able to take place whereby each site could be explored independently and no specific interpretations about each approved premise could be

made. By combining the data across each site and taking a cross-sectional approach, the likely presence of confounding variables was amplified. For example, consideration in the analyses was not able to be given to gender, age or experience of those in working in the environments, and it was not possible to consider environmental factors at each approved premise such as location, access, parking or specific staffing numbers / structure. Furthermore, because of the staff retention difficulties there were only ten participants that took part across all three data collection timepoints at the three approved premises. This was an insufficient sample size to run an analysis investigating if these particular individuals shifted in their views over time. Further research would aim to recruit more research participants, and to explore with these specific individuals how their perspectives changed across time.

In terms of the instruments used, the use of the Post Card Sort Questionnaire could have been improved. Subjectively, the majority of the staff completing the card sort assessments were pressed for time and were required to return to duties in the approved premise. This affected the quantity of the qualitative information they gave about the sorting process. Regarding the psychometric questionnaires, these were not included in the analysis of the research, again because of low numbers resulting in small power calculations and too large confidence intervals for them to be meaningfully interpreted. As such, it was not possible to triangulate the participant's self-report about the atmosphere of the approved premise or their view of working alliance with the residents with the results obtained from the Q-Analyses. Further research will need greater participant numbers to achieve suitable power for analysis.

Furthermore, with regard to the statements used within the Q-Set, feedback received from the participants during the sorting process included that a number of the statements were similar in nature and some were ambiguous, meaning that these were at times difficult to sort. For example, two individuals expressed that they sorted one statement relating to one interpretation at one

timepoint and differently at another (e.g. Statement 14; 'We can trust each other'). Further application of the Q-Set used in this study for future research may benefit from a revision of the statements and a review of the saliency of their meaning.

Finally, this research took place at three approved premises that were also undergoing structural and organisational change in the form of the national E3 restructuring. Although this was not formally implemented until after the third and final time point in two of the three approved premises, one approved premise (MK) experienced this change at the second point of data collection. This overtly had an impact on the researcher's ability to access the participants as data collection was delayed at this approved premise at this time point, i.e. the data was not collected over a discreet period of time and had to be extended. Notwithstanding the practical difficulties of data collection, this research did not have the scope to account for the presence and potential impacts of this organisational change in the design or methodology. It is therefore not possible to fully disentangle the impacts of both the anticipation and expectation of this E3 change and the actual effects it had within the staff's ability to engage with and hold in mind the Enabling Environment therapeutic culture.

10.3 Contributions to Further Research

The application of this research can be twofold. Firstly, the finding that an ideal relationship orientated culture defined by the experts is not consistent with the 'on the floor' perspectives of the staff actually engaged in the approved premises. Future research needs to explore more concretely what can be or needs to be achieved by the staff in such environments, and what they believe to be important functions of their roles. Secondly, the staff experienced difficulties in managing the conflict between offering the therapeutic environment and managing risk and public

protection, and subjectively struggled with managing their relationships with the residents when they were faced with adversity in resources and with conflict. Further research might plan to investigate more specifically the experience of these dual roles and how they are consistent with or contrary to the functions of an approved premise.

Future research should address the core limitations of this study. Particularly, the small sample sizes, having a continuity of participants across time and accounting for some of the confounding variables present in this research. Further research might wish to explore the viewpoints of a wider and greater sample of participants, perhaps through the inclusion of more approved premises or by widening the inclusion criteria. A potential research design to include in further studies might be the use of a single case study design (Creswell, 2013) whereby multiple data points can be collected across time through the quantitative use of psychometric questionnaires as well as gathering rich qualitative information through a methodology such as Thematic analysis (Braun & Clarke, 2006). Similarly, Q methodology can be used with single samples where the same Q-Sorts are completed under a number of different conditions of instruction across time. By analysing the multiple Q-Sorts this then creates a more all-inclusive view of the perspectives held by the individual and can reveal a consolidation of the issues related to their subjective self-perspective (Brown, 1991; Watts & Stenner, 2012).

Similarly, if this study was to be repeated, given the complications in data collection and the approved premises in accomplishing the Enabling Environment standards, data collection would take place over a longer period of time to capture the perspectives and viewpoints of the staff when all of the sites had achieved the Enabling Environment award. Additionally, data would be collected some time post achievement of the Enabling Environment award, for example a six-month follow up of the approved premises to establish whether the principles and subsequent therapeutic culture had sustained, and in what structure.

Given the multifaceted potential confounding variables that might be present in using different sites and consolidating the data, future studies might wish to investigate the different environmental factors at each site and how these might impact the findings. For example, the architectural structure, design and geography of therapeutic environments has been suggested to be related to meaningful engagement and the impact on risk (Emberson, 2017; Moos, 1973).

In this study the psychometric questionnaires were not utilised in the analysis or interpretation of the data because of sample limitations. Further research would look to increase the number of questionnaires to gather more distinct information about the key markers within therapeutic environments. This would however need a greater sample size to achieve any robustness in analysis.

Furthermore, this study focussed on staff as they are the agents of developing and implementing the Enabling Environment initiative. As such this study can only be regarded as a preliminary investigation of the perspectives of staff at these approved premises in the study. Given this research had planned to involve the residents at the approved premises, further studies should look to include the residents in the sample to investigate their experiences and perspectives towards the approved premises and their experience of the Enabling Environment culture. Given the distance found between what experts suggest is important in an ideal Enabling Environment and what is present in the clinical practicality, it would be pertinent to investigate with residents what they feel is important within such a culture. Also, to explore what they themselves as residents feel is both important to them and how they want to experience such an environment in the first three months of being released from prison.

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Appendix 1: Focus Group Semi-Structured Interview

Exploring the perceptions of Approved Premise staff and residents through the emergence of becoming an Enabling Environment.

Brief Background

This research project aims to explore the experiences of both staff working at, and residents living within two National Probation Service Approved Premises as they progress through the development and implementation of a psychologically informed therapeutic environment, i.e. an Enabling Environment (EE).

This project will use a mixed qualitative methodological design, using both a Q-sort methodology and qualitative investigation based on Interpretative Phenomenological Analysis (IPA) methodology. The study is in three parts; (1) the development of the Q-methodology assessment measures through a Concourse and use of an expert panel; (2) Q-methodology card sorts being completed by each staff member staff within both of the two Approved Premises; and (3) a further qualitative analysis (using IPA) investigating the experiences of residents within these two Approved Premises.

In order to undertake the **Concourse** necessary for this study, a number of 'expert' participants will be invited to take part in constructing a robust and reflective review of the subject topic from which the card sort measure will be derived. This will be achieved through four focus groups.

Concourse
Focus Group Questions

1. What do you think constitutes psychologically informed therapeutic environment?

2. What are the factors that contribute towards making a successful therapeutic environment?

3. What factors are helpful in the development of a successful therapeutic environment?

4. What factors are helpful in the maintenance of a successful therapeutic environment?

5. What factors are important or essential to be present within a therapeutic environment?

Appendix 2: Information Sheet for Expert Participants (Focus Group)

Participant Information Sheet A

Focus Groups

Study Title

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Invitation and brief summary

I am a postgraduate student at the University of Roehampton studying for a Doctorate in Forensic Psychology. I am inviting you to take part in research that I am conducting as part of the Doctorate programme. The research is aiming to explore the experiences of both staff working at, and residents living within two National Probation Service Approved premises as they progress through the development and implementation of a psychologically informed culture, i.e. an Enabling Environment (EE).

You are being approached because of your practical and theoretical knowledge and experience of working within psychologically informed therapeutic environments, particularly in Approved Premises and in environments that might be Enabling Environments. A number of individuals that might be termed 'Experts' will be approached to take part in this Study.

Previous research has indicated that the external environment and the therapeutic environment / culture is fundamentally important in promoting engagement and participation in psychological therapies, as well as encouraging and maintaining a readiness and willingness to engage in treatment (Andrews & Bonta, 2003; Howells & Day, 2007; Ward, Day, Howells & Birgden, 2004). In recent years a national Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide therapeutic environments and access to psychological therapies for people with complex needs.

This study has been approved by the Nottingham 2 Research Ethics Committee, under the procedures of the University of Roehampton's Ethics Committee and the NOMS Ethical Review Procedure.

What would taking part involve?

If you decide to participate in the research you will be invited to participate in a one short focus group lasting approximately 30 minutes. I need to recruit approximately 20 individuals for this

aspect of the study. These focus groups can take place at your place of work or at a National Probation site within the Thames Valley Area. This focus group will help me to understand your experiences of what makes up a psychologically informed therapeutic environment, as well as what might contribute towards developing and maintaining a successful therapeutic environment.

If you participate in the research you will be requested to engage in one focus group. These will be audio recorded. Participating in the focus group is entirely optional and the Lead Researcher will discuss this with you prior to the focus group. As soon as all data has been collected your name will be removed from the data and replaced with a research number to ensure anonymity. Your information will be stored in a locked cabinet and on a secure password protected NHS Server.

Participation in the research is entirely voluntary. You may also withdraw your consent to participate in the research which can you do in writing to myself at the details below. You can choose to withdraw at any time. If you choose to not participate in or withdraw from the research for any reason, this will not result any disadvantage you in any way.

What are the possible benefits of taking part?

At this stage it is not possible to predict the outcome of the research and this is why it is important to evaluate the development of Enabling Environments. It is likely that Residents living in, and staff working with Approved Premises in the future may benefit from this research through the development of our understanding of what constitutes an Enabling Environment. Research findings may provide potential recommendations to help with the ongoing development of the Enabling Environments programme within National Probation Service Approved Premises. At present research in this area is very limited so this research will help to provide much needed insight into this under-researched area and may encourage additional service provision.

What are the possible disadvantages of taking part?

Potential risks or burdens to you will be minimal. The focus groups will not involve subject topics that are sensitive in nature, and are unlikely to cause distress. These focus groups are completed as part of the process of evaluating the Enabling Environment process within Two Approved Premises. You will be supported by the Lead researcher in undertaking the focus group measures if you have any mobility or reading or writing difficulties.

In order to minimise patient confidentiality risks and ensure secure storage of data the following procedures will be followed; The focus groups will be digitally tape recorded. Upon consenting to participate in the research, you will be assigned a unique numerical code. At each stage of data collection your name will be removed from data and the code used as an identifier for you. Records of your name and assigned code will be locked in a secure cabinet. Data collected, with assigned identifying codes will be stored in a different locked cabinet. The digital recording device will also be securely stored in a locked cabinet until it has been transcribed, then it will be immediately deleted. The electronic copy will be securely stored on an NHS password protected server. Consent

forms will be kept in a separate locked cabinet. No identifiable information will be incorporated into the writing up of the research report. Data relating to the research will be stored for a period of 5 Years after completion of the research as per NHS Policy. This information will then be securely destroyed.

Independent complaints contact

Should you wish to raise concerns or complaints about the research, there is a formal complaints procedure for you to be able contact. Contact details for this complaints procedure is to write to:

Angela Cossins, Deputy Director, National Probation Service, Queensway House, The Hedges, St Georges, Weston-Super-Mare, North Somerset, BS22 7BB

Alternatively, you can contact University Of Roehampton at;
Dr Diane Bray, The Head of Department, Dept of Psychology, Whitelands College, Holybourne Avenue, London, SW15 4JD, UK. Telephone number: 020 8392 3500

Once the research has been completed you will have the opportunity to receive a summary report of research findings. Should you wish to receive this please let me know in writing at the below address.

Thank you for taking the time to consider participating in the research.

Kind regards
John Cordwell

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Appendix 3: Consent Form

INFORMED CONSENT FORM: Staff / Royal College of Psychiatry Copy

Title of Study:

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Name of CI/PI: John Cordwell

Please initial box:

1.	I confirm that I have read and understood the participant information sheet version number 7 (A or B or C), dated 13.02.17 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without any rights being affected. Although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.	
3.	I understand that choosing not to participate in the research will not result in the removal of treatment or any other disadvantage.	
4.	I understand that the data collected will be analysed and the research may be used for publication. All data will anonymised prior to report write-up and potential publication.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

1 original for participant and 1 copy for study file.

Participant anonymisation code: _____

Appendix 4: Final Q-Set Following Randomisation

1. There needs to be a clear routine to the environment
2. We must be genuine / authentic in how we treat others
3. I keep others welfare in my mind
4. I need to feel supported to do my job
5. I am confident in how to support residents
6. We have a genuine interest in each other
7. I do not take things at face value
8. Residents can depend on each other
9. We value everyone's ideas / thoughts
10. I am thoughtful about the resident's needs
11. We work together as a team
12. Everyone has a voice
13. I try to be curious in why people behave in a certain way
14. We can trust each other
15. There need to be clear expectations about how people behave
16. We should encourage residents to make their own choices
17. Residents can depend on the staff to support them
18. We need to be open to give and receive feedback
19. We have shared goals about the culture between staff and residents
20. I value the resident's contributions to the environment
21. I ask myself 'how does this negative behaviour impact on others within this environment'?
22. I try to be a pro-social role model
23. I keep in mind the whole resident group, not just the individual
24. Residents are able to take care of each other
25. I need strong leadership
26. All interactions with residents should be enabling
27. This needs to be a safe environment
28. We take care of our environment
29. We accept that people make mistakes
30. Residents can predictably get support when they need it
31. We accept each other
32. I look at the person not the problem
33. We relate to each other with a sense of consistency and predictability
34. Not being condemning of others behaviour
35. I take responsibility for a sense of a community
36. I ask myself about the need to keep the public safe
37. I think about the resident's strengths and skills
38. Everyone should be included
39. I need clear reasons for all decisions that are made
40. I treat others fairly
41. We allow everyone to have some autonomy
42. We take a non-judgemental approach
43. There needs to be predictable consequences for people's actions
44. I keep in mind 'can we manage this type of behaviour'
45. The boundaries between staff and resident relationships are clear
46. We help each other to feel that they belong
47. I feel respected and valued
48. I value supervision

49. Feeling safe to share our thoughts and emotions
50. I am thoughtful about how others feel

Appendix 5: Card Sort Mat

Appendix 6: Post Card Sort Interview Questionnaire

Post Card Sort
Assessment Questionnaire

Title of Study:

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Summary

In order to understand how you approached your thinking about what is important to you in an Approved Premise, it would be very helpful to have your perspectives on how you ranked some of the statements.

Please take the time to answer the following questions;

6. Please describe why you found the statements you placed at +5 and +4 most important?

Most Important (+5) Card Numbers _____ & _____:

_____

_____

_____

Important (+4) Card Numbers _____ & _____ & _____:

_____

_____

_____

7. Please describe why you found the statements you placed at -5 and -4 least Important?

Least Important (-5) Card Numbers _____ & _____:

_____

_____

_____

_____

Less Important (-4) Card Numbers _____ & _____ & _____:

_____

_____

_____

8. What specific statements did you have difficulty placing in the grid? Why?

_____

_____

_____

9. Please describe any thoughts you had about Enabling Environments that emerged whilst completing this card sort measure today.

_____

_____

_____

Date:

Time:

Card sort time (1 2 3)

Participant anonymisation code: _____

Appendix 7.1: NHS REC / HRA Ethics Approval Letter

NHS
Health Research Authority

Mr John Cordwell
Senior Forensic Psychologist
Oxford Health NHS Foundation Trust
Littlemore Hospital
Littlemore
Oxford
OX4 4XN

Email: hra.approval@nhs.net

14 February 2017

Dear Mr Cordwell

Letter of HRA Approval

Study title:	**An exploration of the perceptions of staff and residents through the process of becoming an Enabling Environment.**
IRAS project ID:	**203337**
REC reference:	**17/EM/0034**
Sponsor	**University of Roehampton**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Appendix 7.2: NOMS Ethics Approval Letter

National Offender Management Service

John Cordwell
Little Barn
Hempton
Oxford
OX15 0QS

[redacted]
Head of Performance & Quality, SWSC
South West and South Central
3-5 Barnfield Road
Exeter, EX1 1RD

19th January 2017

APPROVED– NOMS RESEARCH

Ref: 2017- 007
Title: An exploration of the perceptions of staff and residents through the process of becoming an Enabling Environment.

Dear Mr Cordwell

Further to your application to undertake research across NOMS, the National Research Committee (NRC) is pleased to grant approval in principle for your research.

Before the research can commence you must agree formally by email to the NRC (National.Research@noms.gsi.gov.uk), confirming that will comply with the terms and conditions outlined below and the expectations set out in the NOMS Research Instruction (https://www.gov.uk/government/organisations/national-offender-management-service/about/research).

Please note that unless the project is commissioned by MoJ/NOMS and signed off by Ministers, the decision to grant access to prison establishments, National Probation Service (NPS) divisions or Community Rehabilitation Company (CRC) areas (and the offenders and practitioners within these establishments/divisions/areas) ultimately lies with the Governing Governor/Director of the establishment or the Deputy Director/Chief Executive of the NPS division/CRC area concerned. If establishments/NPS divisions/CRC areas are to be approached as part of the research, a copy of this letter must be attached to the request to prove that the NRC has approved the study in principle. The decision to grant access to existing data lies with the Information Asset Owners (IAOs) for each data source and the researchers should abide by the data sharing conditions stipulated by each IAO.
Please quote your NRC reference number in all future correspondence.

Yours sincerely,

[redacted]

[redacted]

1

Appendix 7.3: University of Roehampton Final Ethics Approval Email

From: "[redacted]"
Date: 21 February 2017 at 13:44:04 GMT
To: "cordwelj@roehampton.ac.uk" <cordwelj@roehampton.ac.uk>, "Cordwell John (RNU) Oxford Health" <John.Cordwell@oxfordhealth.nhs.uk>
Cc: "[redacted]",
"[redacted]",
"[redacted]"
Subject: Ethics Application Ref: PSYC 16/ 239 - Final Approval

Dear John,

Ethics Application
Applicant: **John Cordwell**
Title: **An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise?**
Reference: **PSYC 16/ 239**
Department: **Psychology**

Many thanks for providing the amended documents as required by the HRA. I can confirm that we have received confirmation of approval for this application from the REC, NOMS and the HRA. Under the procedures agreed by the University Ethics Committee I am pleased to advise you that your Department has confirmed that all conditions for approval of this project have now been met (but please see condition and comment below).

Condition:

Please note that it is your responsibility to meet any conditions imposed by the NHS (including the REC and HRA) and NOMS in respect of this application. This includes requirements to supply documents to other organisations on behalf of the sponsor.

Comment:

We believe that the contact details on page 1 of the Statement of Activities should be your own: it should not be Prof. Marvin as he would not be able to respond to queries regarding the study set up. Please can you change this and confirm once this has been done.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 16/ 239 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 21.02.17.

Please Note:

- **This email confirms that all conditions have been met and thus confirms final ethics approval (it is assumed that you will adhere to any minor conditions still outstanding, therefore we do not require a response to these).**
- **University of Roehampton ethics approval will always be subject to compliance with the University policies and procedures applying at the time when the work takes place. It is your responsibility to ensure that you are familiar and compliant with all such policies and procedures when undertaking your research.**
- **Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.**

Appendix 8.1: Permission to use the Working Alliance Inventory

SOCIETY FOR PSYCHOTHERAPY RESEARCH

August 12, 2018

Dear Mr. John Cordwell:

We have reviewed your request and give permission to use the Working Alliance Inventory (WAI) for the purpose of your research. Use of the WAI is free of charge, however we do require that you publish the following note at the end of the measure:

Reprinted by permission of Society for Psychotherapy Research. © 2016.

Thank you for your interest in furthering psychotherapy research. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

[redacted]
Executive Officer
sprexecutive@gmail.com

http://www.psychotherapyresearch.org phone: 215-898-7253 fax: 215-573-0759

Appendix 8.2: Permission to use the EssenCES Questionnaire (Email)

From: N[redacted]>
Subject: AW: The EssenCES Questionnaire in doctoral research project
Date: 11 October 2017 at 23:05:44 BST
To: john CORDWELL <[redacted]>

Dear John,
thanks for your kind communication. I cannot look through your research proposal immediately as I am attending a conference in Berlin this week – will have a look at it later. Of course I confirm that you are welcome to use the scale in your project.
Best regards Norbert

[redacted]
Psychologe, Dr. rer.nat.
Institut für forensische Psychiatrie am LVR-Klinikum
Universität Duisburg-Essen
0201-7227-335

Von: john CORDWELL [mailto:[redacted]] Gesendet: Mittwoch, 11. Oktober 2017 22:02
An: [redacted] Cc: Cordwell John Oxford Health Betreff: The EssenCES Questionnaire in doctoral research project

Dear Dr [redacted]
I hope this email finds you well.

I have previously contact you when my research was in the design phases to seek permission to use the EssenCES Questionnaire. I am now in the active phases of the research, i.e. I am reaching the stages where I am using the EssenCES Questionnaire and I am writing to reconfirm my wish to use the questionnaire and to reconfirm permissions.

Can I still please continue to use the questionnaire please?

I am a practising Psychologist in the NHS here in the UK undertaking a professional Doctorate research study investigating the experience of staff working in Bail Hostels (here called approved premises) as they progress through a change and implementation of a new therapeutic culture. I am using Q Methodology alongside the EssenCES Questionnaire and Working Alliance Inventory to assess this climate over a 12-18 month period. I really value the EssenCES Questionnaire, as i have previously been involved in a validation study of this measure in Broadmoor Hospital, alongside yourself. I think it is a very helpful measure to investigate views about alliance with patients / residents of these approved premises.

I have attached the research proposal that has since (i.e. in March) been granted permission from the University of Roehampton Ethics Committee, NHS REC Ethics Committee and National Offender Management Service (HM Prison Service) Ethics Committee. I can forward these documents, and any other documents to you that you may require.

Thank you.

I look forward to hearing back from you.
Kind regards
John Cordwell

Appendix 9.1: Information Sheet for Expert Participants (Card Sort)

Participant Information Sheet B

Expert Panel Card Sort

Study Title

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Invitation and brief summary

I am a postgraduate student at the University of Roehampton studying for a Doctorate in Forensic Psychology. I am inviting you to take part in research that I am conducting as part of the Doctorate programme. The research is aiming to explore the experiences of both staff working at, and residents living within two National Probation Service Approved premises as they progress through the development and implementation of a psychologically informed culture, i.e. an Enabling Environment (EE).

You are being approached because of your practical and theoretical knowledge and experience of working within psychologically informed therapeutic environments, particularly in Approved Premises and in environments that might be Enabling Environments. A number of individuals that might be termed 'Experts' will be approached to take part in this Study. You will form part of what is regarded as an 'expert panel'.

Previous research has indicated that the external environment and the therapeutic environment / culture is fundamentally important in promoting engagement and participation in psychological therapies, as well as encouraging and maintaining a readiness and willingness to engage in treatment (Andrews & Bonta, 2003; Howells & Day, 2007; Ward, Day, Howells & Birgden, 2004). In recent years a national Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide therapeutic environments and access to psychological therapies for people with complex needs.

This study has been approved by the Nottingham 2 Research Ethics Committee, under the procedures of the University of Roehampton's Ethics Committee and the NOMS Ethical Review Procedure.

What would taking part involve?

If you decide to participate in the research you will be invited to complete one card sort assessment measure on one occasion. This process will take you approximately 45 minutes. Once you have sorted the cards you will also be asked to complete a post card sort questionnaire. This will take approximately 15 minutes and the discussion will be audio recorded.

These assessments can take place at your place of work or at a National Probation site within the Thames Valley Area. You will be asked to provide any qualitative feedback you may wish to give on the statements you will rank . The card sort assessment measure involves sorting and ranking, in order, a number of statements about Enabling Environments. The card sort assessment measure will help me to understand your viewpoints on what is important in a psychologically informed therapeutic environment, i.e. an Enabling Environment.

If you participate in the research you will be requested to complete one card sort assessment measure on one occasion. Completing the card sort assessment measure is entirely optional and the Lead Researcher will discuss this with you prior to the process. As soon as all data has been collected your name will be removed from the data and replaced with a research number to ensure anonymity.

Participation in the research is entirely voluntary. You may also withdraw your consent to participate in the research which can you do in writing to myself at the details below. You can choose to withdraw at any time. If you choose to not participate in or withdraw from the research for any reason, this will not result any disadvantage you in any way.

What are the possible benefits of taking part?

At this stage it is not possible to predict the outcome of the research and this is why it is important to evaluate the development of Enabling Environments. It is likely that Residents living in, and staff working with Approved Premises in the future may benefit from this research through the development of our understanding of what constitutes an Enabling Environment. Research findings may provide potential recommendations to help with the ongoing development of the Enabling Environments programme within National Probation Service Approved Premises. At present research in this area is very limited so this research will help to provide much needed insight into this under-researched area and may encourage additional service provision.

What are the possible disadvantages of taking part?

Potential risks or burdens to you will be minimal. The card sort assessment measure will not involve subject topics that are sensitive in nature, and are unlikely to cause distress. These card sort assessment measures will be completed as part of the process of evaluating the Enabling Environment process within the Approved Premises. You will be supported by the Lead researcher in undertaking the card sort assessment measure if you have any reading or writing difficulties.

In order to minimise patient confidentiality risks and ensure secure storage of data the following procedures will be followed; The focus groups will be digitally tape recorded. Upon consenting to participate in the research, you will be assigned a unique numerical code. At each stage of data collection your name will be removed from data and the code used as an identifier for you. Records of your name and assigned code will be locked in a secure cabinet. Data collected, with assigned identifying codes will be stored in a different locked cabinet. The digital recording device will also be securely stored in a locked cabinet until it has been transcribed, then it will be immediately deleted. The electronic copy will be securely stored on an NHS password protected server. Consent forms will be kept in a separate locked cabinet. No identifiable information will be incorporated into the writing up of the research report. Data relating to the research will be stored for a period of 5 Years after completion of the research as per NHS Policy. This information will then be securely destroyed.

Independent complaints contact

Should you wish to raise concerns or complaints about the research, there is a formal complaints procedure for you to be able contact. Contact details for this complaints procedure is to write to:

National Probation Service

Angela Cossins, Deputy Director, National Probation Service, Queensway House, The Hedges, St Georges, Weston-Super-Mare, North Somerset, BS22 7BB.

NHS

Victoria Rush, R&D Manager at Victoria.Rush@oxfordhealth.nhs.uk, or on (01865) 902434.

Alternatively, you can contact the University Of Roehampton at;
Dr Diane Bray, The Head of Department, Dept of Psychology, Whitelands College, Holybourne Avenue, London, SW15 4JD, UK. Telephone number: 020 8392 3500 .

Once the research has been completed you will have the opportunity to receive a summary report of research findings. Should you wish to receive this please let me know in writing at the below address.

Thank you for taking the time to consider participating in the research.

Kind regards
John Cordwell

Researcher details: John Cordwell
Department of Psychology, University of Roehampton,
Whitelands College, Holybourne Av, London, SW15 5PJ
cordwelj@roehampton.ac.uk
john.cordwell@nhs.net

Director Of Studies Prof. Robert Edelmann
Department of Psychology, University of Roehampton, Whitelands College, Holybourne Av, London SW15 5PJ.
r.edelmann@roehampton.ac.uk

Head Of Department Dr. Diane Bray
Head of Department, Department of Psychology, University of Roehampton, Whitelands College, Holybourne Av, London, SW15 5PJ.
d.bray@roehampton.ac.uk

Appendix 9.2: Information Sheet for Approved Premise Staff (Card Sort)

Participant Information Sheet C

Approved Premise Staff Card Sort Measure

Study Title

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Invitation and brief summary

I am a postgraduate student at the University of Roehampton studying for a Doctorate in Forensic Psychology. I am inviting you to take part in research that I am conducting as part of the Doctorate programme. The research is aiming to explore the experiences of both staff working at, and residents living within the National Probation Service Approved premises as they progress through the development and implementation of a psychologically informed culture, i.e. an Enabling Environment (EE).

You are being approached because of your valuable experience of working within an Approved Premise, and because you work within an Approved Premise that is going through the development of the Enabling Environments initiative. This Approved Premise has been identified as one of a number sites that is taking part in the research study.

Previous research has indicated that the external environment and the therapeutic environment / culture is fundamentally important in promoting engagement and participation in psychological therapies, as well as encouraging and maintaining a readiness and willingness to engage in treatment (Andrews & Bonta, 2003; Howells & Day, 2007; Ward, Day, Howells & Birgden, 2004). In recent years a national Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide therapeutic environments and access to psychological therapies for people with complex needs.

This study has been approved by the Nottingham 2 Research Ethics Committee, under the procedures of the University of Roehampton's Ethics Committee and the NOMS Ethical Review Procedure.

What would taking part involve?

If you decide to participate in the research you will be invited to complete one card sort assessment measure and three short post-assessment questionnaires at three separate time points across a 12 month period. On each occasion the participation in this will will take you approximately one hour and ten minutes. These assessments can take place at your place of work or at a National Probation site within the Thames Valley Area.

The card sort assessment measure involves sorting and ranking, in order, a number of statements about Approved Premises and Enabling Environments. You will then have the opportunity to provide some qualitative feedback you may wish to give on the statements you will rank. This will be in the form of a short post-assessment questionnaire and this will be audio recorded. The assessment will help me to understand your viewpoints on what is important in a psychologically informed therapeutic environment, i.e. an Enabling Environment.

If you participate in the research you will be requested to complete one card sort measure and the three questionaires on three seperate occasions, several months apart across a 12 month period. Completing these assessments is entirely optional and the Lead Researcher will discuss this with you prior to the process. As soon as all data has been collected your name will be removed from the data and replaced with a research number to ensure anonymity. Your information will be stored in a locked cabinet and on a secure password protected NHS Server.

Participation in the research is entirely voluntary. You may also withdraw your consent to participate in the research which can you do in writing to myself at the details below. You can choose to withdraw at any time. If you choose to not participate in or withdraw from the research for any reason, this will not result any disadvantage you in any way.

What are the possible benefits of taking part?

At this stage it is not possible to predict the outcome of the research and this is why it is important to evaluate the development of Enabling Environments. It is likely that Residents living in, and staff working with Approved Premises in the future may benefit from this research through the development of our understanding of what constitutes an Enabling Environment. Research findings may provide potential recommendations to help with the ongoing development of the Enabling Environments programme within National Probation Service Approved Premises. At present research in this area is very limited so this research will help to provide much needed insight into this under-researched area and may encourage additional service provision.

What are the possible disadvantages of taking part?

Potential risks or burdens to you will be minimal. The card sort measure will not involve subject topics that are sensitive in nature, and are unlikely to cause distress. The card sort measure will be completed as part of the process of evaluating the Enabling Environment process within the Approved Premises. You will be supported by the Lead researcher in undertaking the card sort if you have any reading or writing difficulties.

In order to minimise patient confidentiality risks and ensure secure storage of data the following procedures will be followed; Upon consenting to participate in the research, you will be assigned a unique numerical code. At each stage of data collection your name will be removed from data and the code used as an identifier for you. Records of your name and assigned code will be locked in a secure cabinet. Data collected, with assigned identifying codes will be stored in a different locked cabinet. The digital recording device will also be securey stored in a locked cabinet and the electronic copy securely stored on an NHS password protected server. Consent forms will be kept in a separate locked cabinet. No identifiable information will be incorporated into the writing up of the research report.

Independent complaints contact

Should you wish to raise concerns or complaints about the research, there is a formal complaints procedure for you to be able contact. Contact details for this complaints procedure is to write to:

National Probation Service

Angela Cossins, Deputy Director, National Probation Service, Queensway House, The Hedges, St Georges, Weston-Super-Mare, North Somerset, BS22 7BB

Alternatively, you can contact **University Of Roehampton** at;

Dr Diane Bray, The Head of Department, Dept of Psychology, Whitelands College, Holybourne Avenue, London, SW15 4JD, UK. Telephone number: 020 8392 3500

Once the research has been completed you will have the opportunity to receive a summary report of research findings. Should you wish to receive this please let me know in writing at the below address.

Thank you for taking the time to consider participating in the research.

Kind regards
John Cordwell

Researcher details: John Cordwell
Department of Psychology, University of Roehampton,
Whitelands College, Holybourne Av, London, SW15 5PJ
cordwelj@roehampton.ac.uk
john.cordwell@nhs.net

Director Of Studies Prof. Robert Edelmann
Department of Psychology, University of Roehampton, Whitelands College, Holybourne Av, London SW15 5PJ.
r.edelmann@roehampton.ac.uk

Head Of Department Dr. Diane Bray
Head of Department, Department of Psychology, University of Roehampton, Whitelands College, Holybourne Av, London, SW15 5PJ.
d.bray@roehampton.ac.uk

Appendix 10.1: Participant Instructions Expert Panel (Card Sort)

Participant Instructions
Expert panel

Card Sort Measure

Study Title

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Project Summary

You are being approached because of your practical and theoretical knowledge and experience of working within psychologically informed therapeutic environments, particularly in Approved Premises and in environments that might be Enabling Environments. A number of individuals that might be termed 'Experts' will be approached to take part in this Study. You will form part of what is regarded as an 'expert panel'.

Previous research has indicated that the external environment and the therapeutic environment / culture is fundamentally important in promoting engagement and participation in psychological therapies, as well as encouraging and maintaining a readiness and willingness to engage in treatment (Andrews & Bonta, 2003; Howells & Day, 2007; Ward, Day, Howells & Birgden, 2004). In recent years a national Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide therapeutic environments and access to psychological therapies for people with complex needs.

This study has been approved by the NHS IRAS Ethical Review Panel, under the procedures of the University of Roehampton's Ethics Committee and the NOMS Ethical review Procedure.

Instructions for completing the Card Sort Questionnaire

1. This research needs your perspectives about what is important within an ideal Enabling Environment. This card sort questionnaire asks you to rank the following statements. Please rank the given statements based upon;

"How important do you think each statement reflects an ideal Enabling Environment"

2. Read the statements on each card with this in mind

3. Based on your initial reaction to each statement, sort the cards into one of the three piles at the top of the mat, i.e. Most Important, Least Important or Neutral. Statements that you are not sure of should go in the Neutral pile. Do not spend more than a couple of minutes on this part.

4. Choose either the Most Important or Least Important pile, and take a little more time to sort the statement cards on your grid according to the strength of your feelings about each statement. For example, put the statement that you find Most Important with in the spot marked "+5 Most Important." Sort through the remaining statements from this pile and place them in the remaining columns.

5. You should not have any more or any less cards than the spaces provided.

6. Once you are finished with the Most Important pile, move on to the Least Important pile, and repeat the process, starting by putting the statement you find Least Important with in the spot marked "-5 Least Important."

7. Save the Neutral pile for last.

8. Think of these middle columns as a continuum, not as a strict Most Important or Least Important. It is ok to have some overlap from your initial sort piles, and where they finally end up on your grid. Feel free to move the cards around and adjust them until you get your grid just like you want it.

9. When you are satisfied with the order of your cards on the grid let the Lead Researcher know. They will then make a note of where you have placed the cards in the grid.

10. You may struggle with ranking some statements and think, "What do they mean by that?" You now have a chance to describe what your thoughts or ideas are about any statement.

11. You will be asked to complete the post card sort questionnaire and two further questionnaires (the EssenCES and Working Alliance Inventory).

Thank you for taking the time to complete this card sort measure.

Kind regards
John Cordwell

Researcher details: John Cordwell
Department of Psychology, University of Roehampton,
Whitelands College, Holybourne Av, London, SW15 5PJ
cordwelj@roehampton.ac.uk
john.cordwell@nhs.net

Director Of Studies Prof. Robert Edelmann
Department of Psychology, University of Roehampton, Whitelands College, Holybourne Av, London SW15 5PJ.
r.edelmann@roehampton.ac.uk

Head Of Department Dr. Diane Bray
Head of Department, Department of Psychology, University of Roehampton, Whitelands College, Holybourne Av, London, SW15 5PJ.
d.bray@roehampton.ac.uk

Appendix 10.2: Participant Instructions Approved Premise Staff (Card Sort)

Participant Instructions

Approved Premise Staff

Card Sort Measure

Study Title

An exploration of the perceptions of staff and residents through the emergence of becoming an Enabling Environment in an Approved Premise.

Project Summary

You are being approached because of your practical and theoretical knowledge and experience of working within psychologically informed therapeutic environments, particularly in Approved Premises and in environments that might be Enabling Environments. A number of individuals that might be termed 'Experts' will be approached to take part in this Study. You will form part of what is regarded as an 'expert panel'.

Previous research has indicated that the external environment and the therapeutic environment / culture is fundamentally important in promoting engagement and participation in psychological therapies, as well as encouraging and maintaining a readiness and willingness to engage in treatment (Andrews & Bonta, 2003; Howells & Day, 2007; Ward, Day, Howells & Birgden, 2004). In recent years a national Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide therapeutic environments and access to psychological therapies for people with complex needs.

This study has been approved by the NHS IRAS Ethical Review Panel, under the procedures of the University of Roehampton's Ethics Committee and the NOMS Ethical review Procedure.

Instructions for completing the Card Sort measure (Adapted from Walker, 2013)

1. This research needs your perspectives about what is important within an Approved Premise. This card sort measure asks you to rank the statements in an order. Please rank the given statements based upon;

"**how important are these statement to you".**

2. Read the statements on each card with this in mind

3. Based on your initial reaction to each statement, sort the cards into one of the three piles at the top of the mat, i.e. Agree, Disagree or Neutral. Statements that you are not sure of should go in the neutral pile. Do not spend more than a couple of minutes on this part.

4. Choose either the Agree or Disagree pile, and take a little more time to sort the statement cards on your grid according to the strength of your feelings about each statement. For example, put the statement that you most agree with in the spot marked "+5 most agree." Sort through the remaining statements from this pile and place them in the remaining columns.

5. You should not have any more or any less cards than the spaces provided.

6. Once you are finished with the Agree pile, move on to the Disagree pile, and repeat the process, starting by putting the statement you most disagree with in the spot marked "-5 most disagree."

7. Save the neutral pile for last.

8. Think of these middle columns as a continuum, not as a strict Agree or Disagree. It is ok to have some overlap from your initial sort piles, and where they finally end up on your grid. Feel free to move the cards around and adjust them until you get your grid just like you want it.

9. When you are satisfied with the order of your cards on the grid let the Lead Researcher know. They will then make a note of where you have placed the cards in the grid.

10. You may struggle with ranking some statements and think, "What do they mean by that?" You now have a chance to describe what your thoughts or ideas are about any statement.

11. You will be asked to complete the post card sort questionnaire

Thank you for taking the time to complete this card sort measure.

Kind regards
John Cordwell

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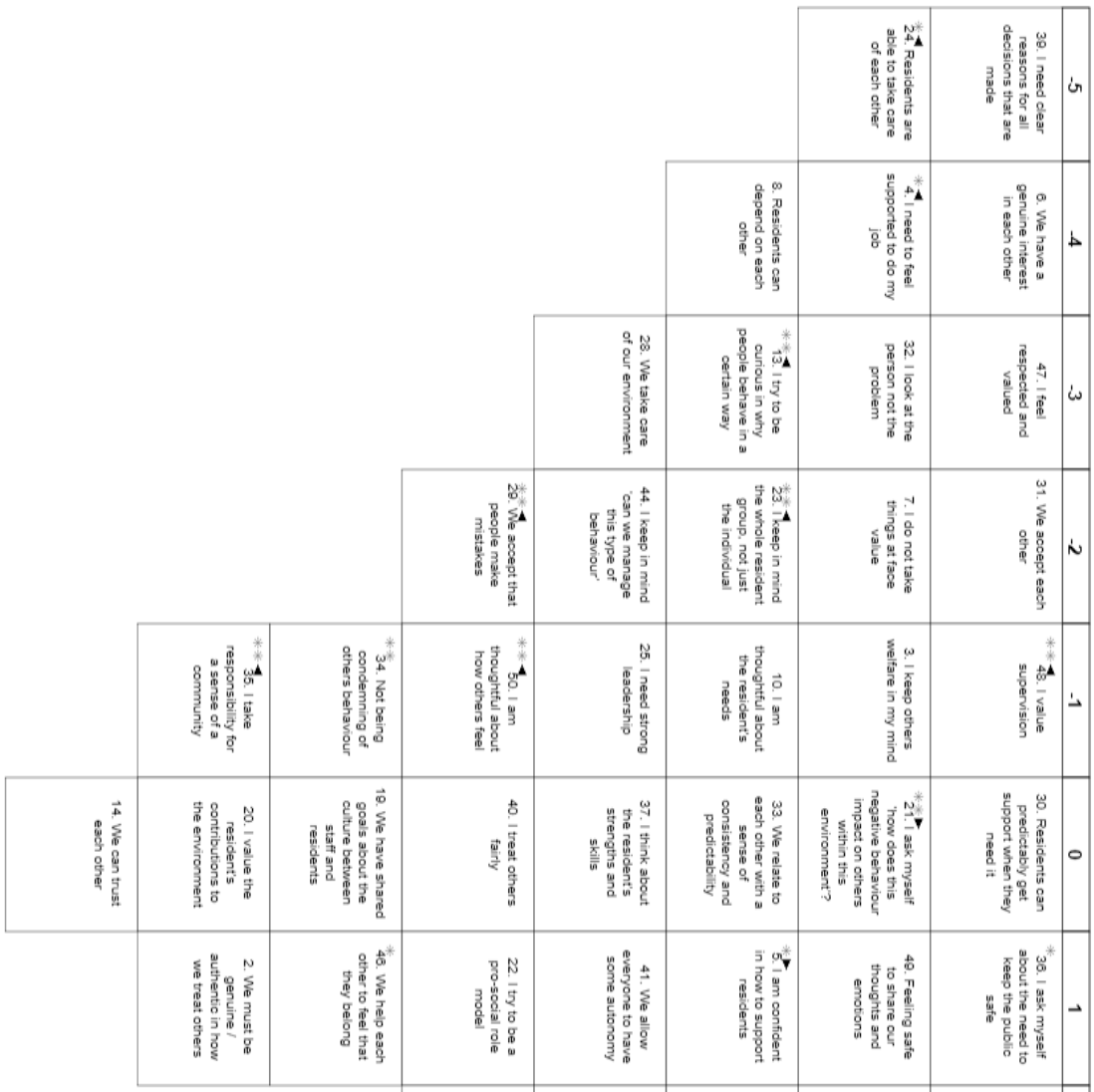
Appendix 11: Correlation Matrix for the Expert Participants

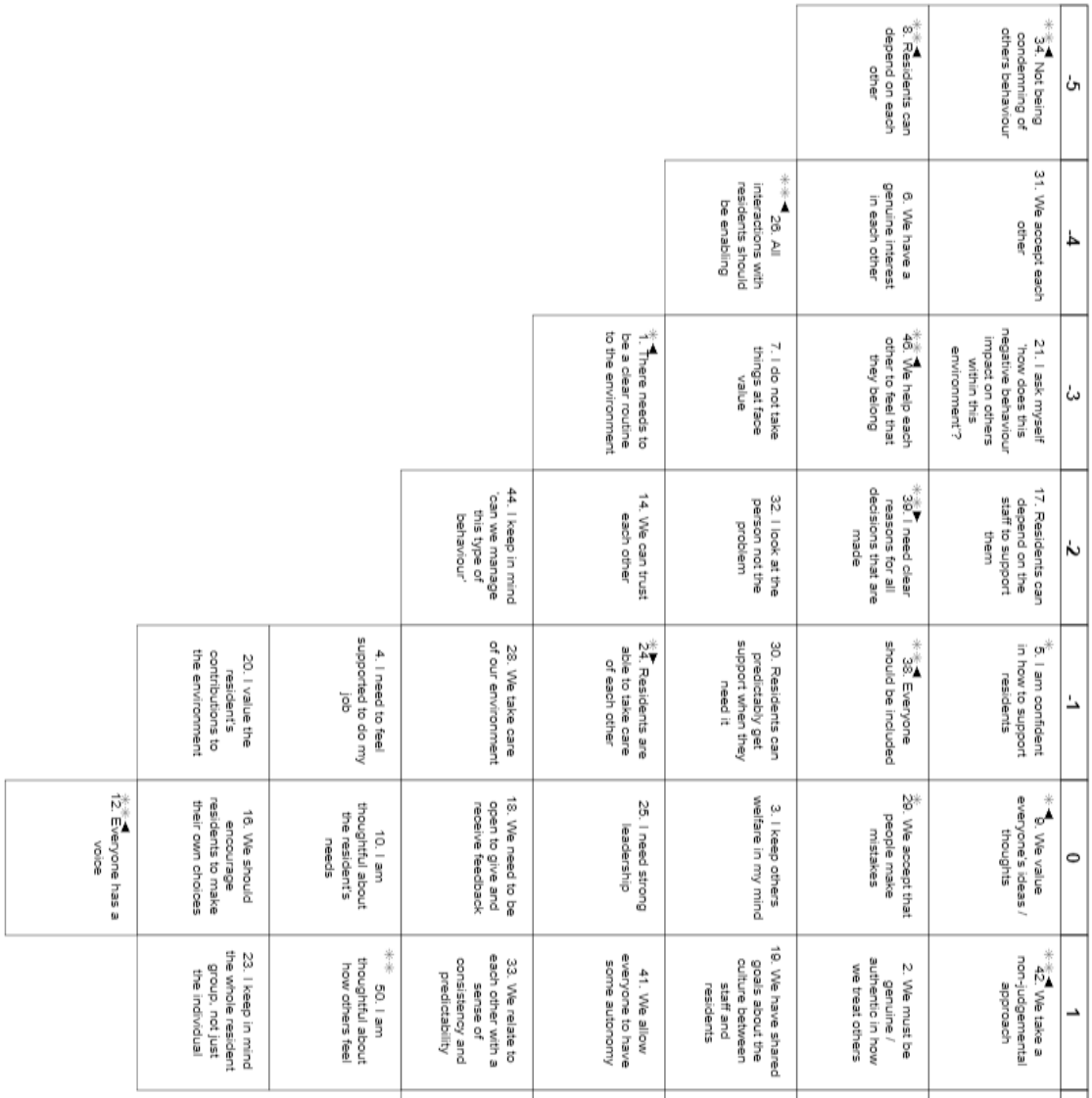
Correlations Between Q Sorts - Expert Participants

Participant	E1	E2	E3	E4	E5	E6	E7	E8	E9	E10	E11	E12	E13	E14	E15	E16	E17	E18	E19	E20	E21
E1	100	23	-4	14	-3	8	2	-13	-33	0	11	-23	-8	3	10	-5	16	14	-11	20	43
E2	23	100	25	62	22	30	27	21	11	30	52	12	43	2	20	64	51	49	-4	42	29
E3	-4	25	100	21	26	42	31	-6	9	-10	25	13	43	39	11	48	25	37	26	27	28
E4	14	62	21	100	9	6	7	27	-2	20	39	14	43	6	15	44	43	37	9	41	23
E5	-3	22	26	9	100	9	42	42	31	27	4	37	21	19	26	20	7	13	35	9	19
E6	8	30	42	6	9	100	30	3	-3	-4	34	2	15	11	15	34	34	34	9	12	18
E7	2	27	31	7	42	30	100	35	13	28	28	28	33	18	-9	11	12	-2	23	25	40
E8	-13	21	-6	27	42	3	35	100	10	33	19	35	41	13	26	34	-12	-1	0	32	-1
E9	-33	11	9	-2	31	-3	13	10	100	5	-4	23	-12	17	-16	11	3	21	12	3	-21
E10	0	30	-10	20	27	-4	28	33	5	100	29	4	35	-9	17	16	10	-2	21	3	6
E11	11	52	25	39	4	34	28	19	-4	29	100	13	37	-9	34	38	18	7	-1	5	8
E12	-23	12	13	14	37	2	28	35	23	4	13	100	31	10	6	24	-29	-5	27	4	2
E13	-8	43	43	43	21	15	33	41	-12	35	37	31	100	15	18	55	15	21	8	33	18
E14	3	2	39	6	19	11	18	13	17	-9	-9	10	15	100	-11	19	14	42	-5	23	3
E15	10	20	11	15	26	15	-9	26	-16	17	34	6	18	-11	100	25	-5	16	2	-23	14
E16	-5	64	48	44	20	34	11	34	11	16	38	24	55	19	25	100	33	48	-5	55	-2
E17	16	51	25	43	7	34	12	-12	3	10	18	-29	15	14	-5	33	100	44	9	40	32
E18	14	49	37	37	13	34	-2	-1	21	-2	7	-5	21	42	16	48	44	100	2	37	20
E 19	-11	-4	26	9	35	9	23	0	12	21	-1	27	8	-5	2	-5	9	2	100	0	19
E20	20	42	27	41	9	12	25	32	3	3	5	4	33	23	-23	55	40	37	0	100	20
E21	43	29	28	23	19	18	40	-1	-21	6	8	2	18	3	14	-2	32	20	19	20	100

Appendix 12.1: Factor Array for Factor B (The Predictable System)



Appendix 12.2: Factor Array for Factor C (The Modelling Team)



Appendix 13.1: Crib Sheet for Factor A (The Safe Relating Space)

Relative Ranking of Statements in factor A

Statements	Highest Ranked Statements	factor A	Consensus / Distinguishing	factor B	factor C
49	Feeling safe to share our thoughts and emotions	5	D*	1	2
42	We take a non-judgemental approach	5		4	1
	Positive Statements Ranked Higher in factor A Array than in Other Factor Arrays				
13	I try to be curious in why people behave in a certain way	4	D*	-3	2
12	Everyone has a voice	4	D	2	0
50	I am thoughtful about how others feel	4	D*	-1	1
18	We need to be open to give and receive feedback	3	D*	2	0
35	I take responsibility for a sense of a community	3		-1	3
34	Not being condemning of others behaviour	3	D*	-1	-5
46	We help each other to feel that they belong	3	D	1	-3
29	We accept that people make mistakes	2	D	-2	0
38	Everyone should be included	2		2	-1
2	We must be genuine / authentic in how we treat others	2	C*	1	1
6	We have a genuine interest in each other	1	D*	-4	-4
19	We have shared goals about the culture between staff and residents	1	C*	0	1
23	I keep in mind the whole resident group, not just the individual	1		-2	1
33	We relate to each other with a sense of consistency and predictability	1	C*	0	1
41	We allow everyone to have some autonomy	1	C*	1	1
28	We take care of our environment	0	D	-3	-1
7	I do not take things at face value	0	D*	-2	-3
20	I value the resident's contributions to the environment	0	C	0	-1
4	I need to feel supported to do my job	0		-4	-1
	Negative Statements Ranked Lower in factor A Array than in Other Factor Arrays				
45	The boundaries between staff and resident relationships are clear	0	D*	5	4
11	We work together as a team	0	D	4	2
40	I treat others fairly	0		0	4
22	I try to be a pro-social role model	-1		1	4
3	I keep others welfare in my mind	-1	C*	-1	0
30	Residents can predictably get support when they need it	-1	C	0	-1
25	I need strong leadership	-1	C*	-1	0
15	There need to be clear expectations about how people behave	-2	D*	4	5
14	We can trust each other	-2	C	0	-2
10	I am thoughtful about the resident's needs	-2	C	-1	0
37	I think about the resident's strengths and skills	-3	D*	0	2
21	I ask myself 'how does this negative behaviour impact on others within this environm	-3		0	-3
17	Residents can depend on the staff to support them	-3		3	-2
43	There needs to be predictable consequences for people's actions	-3	D*	2	2
5	I am confident in how to support residents	-4	D*	1	-1
44	I keep in mind 'can we manage this type of behaviour'	-4	D	-2	-2
	Lowest Ranked Statements				
39	I need clear reasons for all decisions that are made	-5		-5	-2
36	I ask myself about the need to keep the public safe	-5	D*	1	3

Appendix 13.2: Crib Sheet for Factor B (The Predictable System)

Relative Ranking of Statements in factor B

Statement	Highest Ranked Statements	factor B	Consensus / Distinguishing	factor A	factor C
27	This needs to be a safe environment	5	D	1	5
45	The boundaries between staff and resident relationships are clear	5		0	4
	Positive Statements Ranked Higher in factor B Array than in Other Factor Arrays				
11	We work together as a team	4	D*	0	2
1	There needs to be a clear routine to the environment	3	D*	-1	-3
9	We value everyone's ideas / thoughts	3		2	0
17	Residents can depend on the staff to support them	3	D*	-3	-2
26	All interactions with residents should be enabling	3	D*	0	-4
38	Everyone should be included	2		2	-1
43	There needs to be predictable consequences for people's actions	2		-3	2
16	We should encourage residents to make their own choices	2	C	1	0
5	I am confident in how to support residents	1	D	-4	-1
41	We allow everyone to have some autonomy	1	C*	1	1
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	D*	-3	-3
30	Residents can predictably get support when they need it	0	C	-1	-1
20	I value the resident's contributions to the environment	0	C	0	-1
14	We can trust each other	0	C	-2	-2
	Negative Statements Ranked Lower in factor B Array than in Other Factor Arrays				
33	We relate to each other with a sense of consistency and predictability	0	C*	1	1
40	I treat others fairly	0		0	4
19	We have shared goals about the culture between staff and residents	0	C*	1	1
48	I value supervision	-1	D*	2	3
3	I keep others welfare in my mind	-1	C*	-1	0
25	I need strong leadership	-1	C*	-1	0
50	I am thoughtful about how others feel	-1	D*	4	1
35	I take responsibility for a sense of a community	-1	D*	3	3
23	I keep in mind the whole resident group, not just the individual	-2	D*	1	1
29	We accept that people make mistakes	-2	D*	2	0
47	I feel respected and valued	-3		-2	3
32	I look at the person not the problem	-3	C*	-1	-2
13	I try to be curious in why people behave in a certain way	-3	D*	4	2
28	We take care of our environment	-3		0	-1
6	We have a genuine interest in each other	-4		1	-4
4	I need to feel supported to do my job	-4	D	0	-1
	Lowest Ranked Statements				
39	I need clear reasons for all decisions that are made	-5		-5	-2
24	Residents are able to take care of each other	-5	D	-4	-1

Appendix 13.3: Crib Sheet for Factor C (The Modelling Team)

Relative Ranking of Statements in factor C

Statements	Highest Ranked Statements	factor C	Consensus / Distinguishing	factor A	factor B
15	There need to be clear expectations about how people behave	5	D	-2	4
27	This needs to be a safe environment	5	D	1	5
	Positive Statements Ranked Higher in factor C Array than in Other Factor Arrays				
22	I try to be a pro-social role model	4	D*	-1	1
40	I treat others fairly	4	D*	0	0
35	I take responsibility for a sense of a community	3		3	-1
36	I ask myself about the need to keep the public safe	3	D	-5	1
47	I feel respected and valued	3	D*	-2	-3
48	I value supervision	3		2	-1
43	There needs to be predictable consequences for people's actions	2		-3	2
37	I think about the resident's strengths and skills	2		-3	0
19	We have shared goals about the culture between staff and residents	1	C*	1	0
41	We allow everyone to have some autonomy	1	C*	1	1
33	We relate to each other with a sense of consistency and predictability	1	C*	1	0
23	I keep in mind the whole resident group, not just the individual	1		1	-2
3	I keep others welfare in my mind	0	C*	-1	-1
25	I need strong leadership	0	C*	-1	-1
10	I am thoughtful about the resident's needs	0	C	-2	-1
	Negative Statements Ranked Lower in factor C Array than in Other Factor Arrays				
9	We value everyone's ideas / thoughts	0	D	2	3
18	We need to be open to give and receive feedback	0		3	2
16	We should encourage residents to make their own choices	0	C	1	2
12	Everyone has a voice	0	D*	4	2
38	Everyone should be included	-1	D*	2	2
30	Residents can predictably get support when they need it	-1	C	-1	0
20	I value the resident's contributions to the environment	-1	C	0	0
14	We can trust each other	-2	C	-2	0
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	-3		-3	0
46	We help each other to feel that they belong	-3	D*	3	1
7	I do not take things at face value	-3		0	-2
1	There needs to be a clear routine to the environment	-3	D	-1	3
31	We accept each other	-4	C	-1	-2
6	We have a genuine interest in each other	-4		1	-4
26	All interactions with residents should be enabling	-4	D*	0	3
	Lowest Ranked Statements				
34	Not being condemning of others behaviour	-5	D*	3	-1
8	Residents can depend on each other	-5	D*	-2	-4

Appendix 13.4: Consensus Statements for the Expert Factors

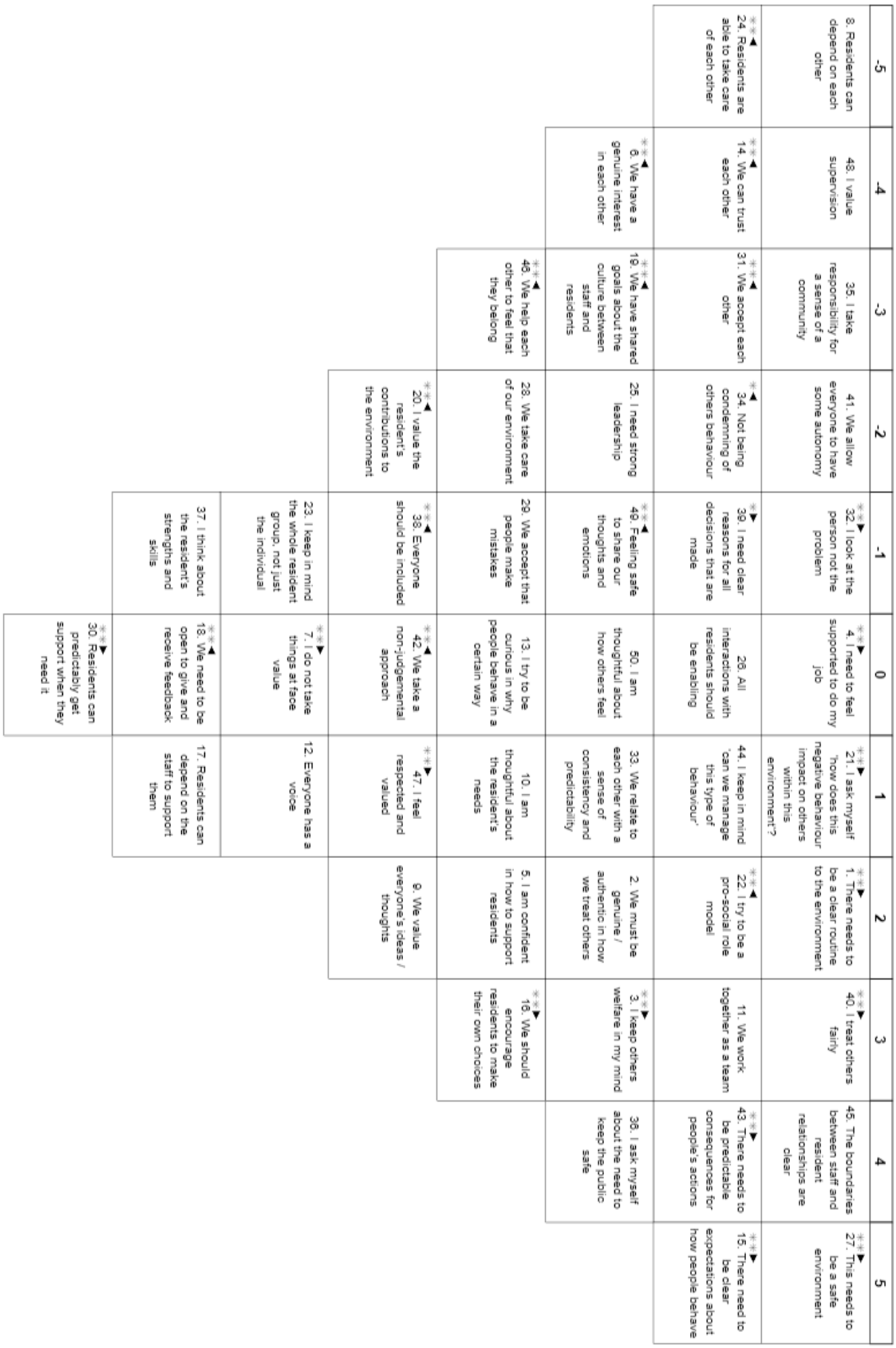
Statement Number	Statement	Factor A Q-SV	Factor A Z-score	Factor B Q-SV	Factor B Z-score	Factor C Q-SV	Factor C Z-score
2	We must be genuine / authentic in how we treat others*	2	0.553	1	0.215	1	0.55
3	I keep others welfare in my mind*	-1	-0.468	-1	-0.195	0	-0.038
10	I am thoughtful about the resident's needs	-2	-0.83	-1	-0.266	0	-0.12
14	We can trust each other	-2	-0.778	0	-0.13	-2	-0.84
16	We should encourage residents to make their own choices	1	0.334	2	0.52	0	-0.16
19	We have shared goals about the culture between staff and residents*	1	0.446	0	0.075	1	0.486
20	I value the resident's contributions to the environment	0	0.1	0	0.023	-1	-0.6
25	I need strong leadership*	-1	-0.638	-1	-0.555	0	-0.041
30	Residents can predictably get support when they need it	-1	-0.53	0	0.142	-1	-0.487
31	We accept each other	-1	-0.45	-2	-0.829	-4	-1.32
32	I look at the person not the problem*	-1	-0.46	-3	-1.045	-2	-0.764
33	We relate to each other with a sense of consistency and predictability*	1	0.307	0	0.125	1	0.354
41	We allow everyone to have some autonomy*	1	0.272	1	0.376	1	0.486
44	I keep in mind 'can we manage this type of behaviour'	-4	-1.67	-2	-0.92	-2	-0.84

NB: All Listed Statements are Non-Significant at P > 0.01. Those Flagged with (*) are also Non-Significant at P > 0.05).

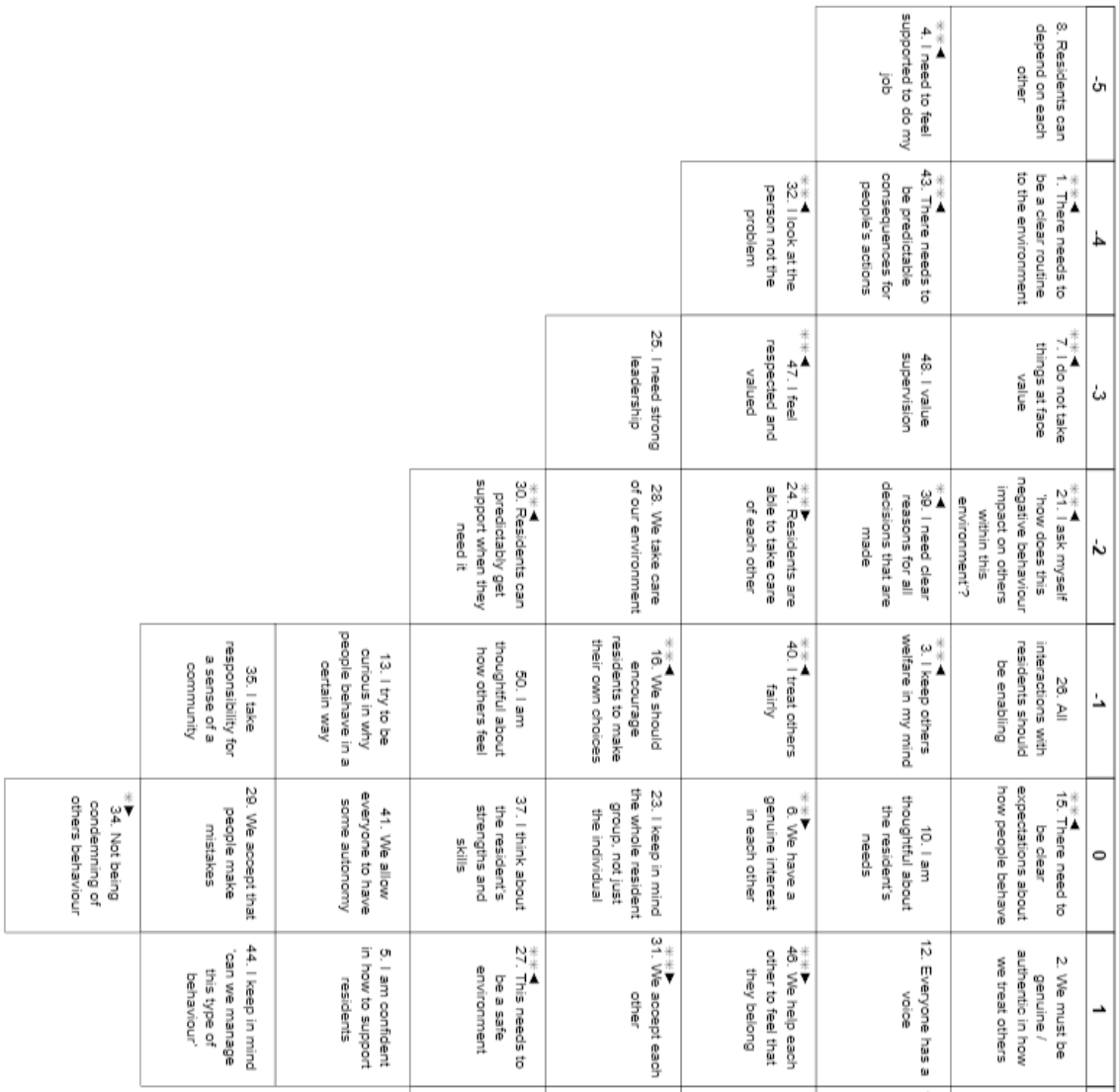
Appendix 14: Correlation Matrix for the Approved Premise Staff at Time One (Baseline)

Correlations between Q sorts - Approved Premise Staff Time One (Baseline)													
Participant	**T1 A1**	**T1 A2**	**T1 A3**	**T1 A4**	**T1 A5**	**T1 B1**	**T1 B2**	**T1 B3**	**T1 B4**	**T1 B5**	**T1 C1**	**T1 C2**	**T1 C3**	**T1 C4**
T1 A1	100	-2	1	-3	22	28	57	10	50	-1	19	6	6	47
T1 A2	-2	100	51	2	9	9	5	2	19	5	17	15	41	25
T1 A3	1	51	100	-15	-6	8	7	14	-4	11	10	27	28	30
T1 A4	-3	2	-15	100	45	8	-3	19	-26	27	25	12	7	24
T1 A5	22	9	-6	45	100	25	12	27	0	33	35	32	28	30
T1 B1	28	9	8	8	25	100	20	56	19	20	70	52	33	40
T1 B2	57	5	7	-3	12	20	100	-9	17	-25	17	-13	-10	20
T1 B3	10	2	14	19	27	56	-9	100	30	40	61	44	48	43
T1 B4	50	19	-4	-26	0	19	17	30	100	-4	21	10	10	18
T1 B5	-1	5	11	27	33	20	-25	40	-4	100	38	39	52	21
T1 C1	19	17	10	25	35	70	17	61	21	38	100	42	49	31
T1 C2	6	15	27	12	32	52	-13	44	10	39	42	100	47	28
T1 C3	6	41	28	7	28	33	-10	48	10	52	49	47	100	44
T1 C4	47	25	30	24	30	40	20	43	18	21	31	28	44	100

Appendix 15.1: Factor Array for Factor 1.1 (The Predictable Environment)



Appendix 15.2: Factor Array for Factor 1.2 (Inclusion and Acceptance)



Appendix 16.1: Crib Sheet for Factor 1.1 (The Predictable Environment)

Relative Ranking of Statements in factor 1.1

Statements	Highest Ranked Statements	factor 1.1	Consensus / Distinguishing	factor 1.2
27	This needs to be a safe environment	5	D*	1
15	There need to be clear expectations about how people behave	5	D*	0
	Positive Statements Ranked Higher in factor 1.1 Array than in Other Factor Arrays			
45	The boundaries between staff and resident relationships are clear	4	C*	3
43	There needs to be predictable consequences for people's actions	4	D*	-4
36	I ask myself about the need to keep the public safe	4	C*	3
40	I treat others fairly	3	D*	-1
3	I keep others welfare in my mind	3	D*	-1
16	We should encourage residents to make their own choices	3	D*	-1
1	There needs to be a clear routine to the environment	2	D*	-4
2	We must be genuine / authentic in how we treat others	2	C*	1
5	I am confident in how to support residents	2	C*	1
9	We value everyone's ideas / thoughts	2	C*	2
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	1	D*	-2
44	I keep in mind 'can we manage this type of behaviour'	1	C*	1
10	I am thoughtful about the resident's needs	1	C*	0
47	I feel respected and valued	1	D*	-3
12	Everyone has a voice	1	C*	1
4	I need to feel supported to do my job	0	D*	-5
26	All interactions with residents should be enabling	0	C*	-1
50	I am thoughtful about how others feel	0	C*	-1
13	I try to be curious in why people behave in a certain way	0	C*	-1
7	I do not take things at face value	0	D*	-3
30	Residents can predictably get support when they need it	0	D*	-2
	Negative Statements Ranked Lower in factor 1.1 Array than in Other Factor Arrays			
42	We take a non-judgemental approach	0	D*	3
18	We need to be open to give and receive feedback	0	D*	5
49	Feeling safe to share our thoughts and emotions	-1	D*	3
29	We accept that people make mistakes	-1	C*	0
38	Everyone should be included	-1	D*	5
23	I keep in mind the whole resident group, not just the individual	-1	C*	0
37	I think about the resident's strengths and skills	-1	C*	0
41	We allow everyone to have some autonomy	-2	C*	0
34	Not being condemning of others behaviour	-2	D	0
28	We take care of our environment	-2	C*	-2
20	I value the resident's contributions to the environment	-2	D*	2
35	I take responsibility for a sense of a community	-3	C*	-1
31	We accept each other	-3	D*	1
19	We have shared goals about the culture between staff and residents	-3	D*	2
46	We help each other to feel that they belong	-3	D*	1
48	I value supervision	-4	C*	-3
14	We can trust each other	-4	D*	4
6	We have a genuine interest in each other	-4	D*	0
	Lowest Ranked Statements			
8	Residents can depend on each other	-5	C*	-5
24	Residents are able to take care of each other	-5	D*	-2

Appendix 16.2: Crib Sheet for Factor 1.2 (Inclusion and Acceptance)

Relative Ranking of Statements in factor 1.2

Statement	Highest Ranked Statements	factor 1.2	Consensus / Distinguishing	factor 1.1
38	Everyone should be included	5	D*	-1
18	We need to be open to give and receive feedback	5	D*	0
	Positive Statements Ranked Higher in factor 1.2 Array than in Other Factor Arrays			
22	I try to be a pro-social role model	4	D*	2
11	We work together as a team	4	C*	3
14	We can trust each other	4	D*	-4
49	Feeling safe to share our thoughts and emotions	3	D*	-1
42	We take a non-judgemental approach	3	D*	0
20	I value the resident's contributions to the environment	2	D*	-2
19	We have shared goals about the culture between staff and residents	2	D*	-3
9	We value everyone's ideas / thoughts	2	C*	2
33	We relate to each other with a sense of consistency and predictability	2	C*	1
17	Residents can depend on the staff to support them	2	C*	1
12	Everyone has a voice	1	C*	1
46	We help each other to feel that they belong	1	D*	-3
31	We accept each other	1	D*	-3
44	I keep in mind 'can we manage this type of behaviour'	1	C*	1
6	We have a genuine interest in each other	0	D*	-4
23	I keep in mind the whole resident group, not just the individual	0	C*	-1
37	I think about the resident's strengths and skills	0	C*	-1
41	We allow everyone to have some autonomy	0	C*	-2
29	We accept that people make mistakes	0	C*	-1
34	Not being condemning of others behaviour	0	D	-2
	Negative Statements Ranked Lower in factor 1.2 Array than in Other Factor Arrays			
15	There need to be clear expectations about how people behave	0	D*	5
10	I am thoughtful about the resident's needs	0	C*	1
26	All interactions with residents should be enabling	-1	C*	0
3	I keep others welfare in my mind	-1	D*	3
40	I treat others fairly	-1	D*	3
16	We should encourage residents to make their own choices	-1	D*	3
50	I am thoughtful about how others feel	-1	C*	0
13	I try to be curious in why people behave in a certain way	-1	C*	0
21	I ask myself 'how does this negative behaviour impact on others within this environm	-2	D*	1
39	I need clear reasons for all decisions that are made	-2	D	-1
28	We take care of our environment	-2	C*	-2
30	Residents can predictably get support when they need it	-2	D*	0
7	I do not take things at face value	-3	D*	0
47	I feel respected and valued	-3	D*	1
25	I need strong leadership	-3	C*	-2
1	There needs to be a clear routine to the environment	-4	D*	2
43	There needs to be predictable consequences for people's actions	-4	D*	4
32	I look at the person not the problem	-4	D*	-1
	Lowest Ranked Statements			
8	Residents can depend on each other	-5	C*	-5
4	I need to feel supported to do my job	-5	D*	0

Appendix 16.3: Consensus Statements at Time One

Statement Number	Statement	Factor 1.1 Q-SV	Factor 1.1 Z-score	Factor 1.2 Q-SV	Factor 1.2 Z-score
2	We must be genuine / authentic in how we treat others*	2	0.552	1	0.608
5	I am confident in how to support residents*	2	0.521	1	0.375
8	Residents can depend on each other*	-5	-2.377	-5	-2.067
9	We value everyone's ideas / thoughts*	2	0.51	2	0.814
10	I am thoughtful about the resident's needs*	1	0.224	0	0.186
11	We work together as a team*	3	1.041	4	1.531
12	Everyone has a voice*	1	0.193	1	0.602
13	I try to be curious in why people behave in a certain way*	0	0.078	-1	-0.468
17	Residents can depend on the staff to support them*	1	0.161	2	0.643
23	I keep in mind the whole resident group, not just the individual*	-1	-0.444	0	0.149
25	I need strong leadership*	-2	-0.811	-3	-1.316
26	All interactions with residents should be enabling*	0	0.129	-1	-0.217
28	We take care of our environment*	-2	-0.816	-2	-0.914
29	We accept that people make mistakes*	-1	-0.372	0	0.012
33	We relate to each other with a sense of consistency and predictability*	1	0.33	2	0.783
34	Not being condemning of others behaviour	-2	-0.79	0	-0.09
35	I take responsibility for a sense of a community*	-3	-0.854	-1	-0.61
36	I ask myself about the need to keep the public safe*	4	1.531	3	1.048
37	I think about the resident's strengths and skills*	-1	-0.462	0	0.063
39	I need clear reasons for all decisions that are made	-1	-0.15	-2	-0.77
41	We allow everyone to have some autonomy*	-2	-0.466	0	0.037
44	I keep in mind 'can we manage this type of behaviour'*	1	0.398	1	0.362
45	The boundaries between staff and resident relationships are clear*	4	1.734	3	1.185
48	I value supervision*	-4	-1.197	-3	-1.198
50	I am thoughtful about how others feel*	0	0.116	-1	-0.425

NB: All Listed Statements are Non-Significant at P > 0.01. Those Flagged with (*) are also Non-Significant at P > 0.05).

Appendix 17: Correlation Matrix for the Approved Premise Staff at Time Two

Correlations between Q sorts - Approved Premise Staff Time Two																				
Participant	T2 A2	T2 A4	T2 A5	T2 A6	T2 A7	T2 A8	T2 A9	T2 B1	T2 B2	T2 B4	T2 B5	T2 B6	T2 B7	T2 C1	T2 C2	T2 C3	T2 C4	T2 C5
T2 A2	100	4	23	22	16	34	20	22	6	26	32	15	39	18	11	18	29	10
T2 A4	4	100	27	33	26	15	-17	19	18	18	12	12	27	27	2	18	34	22
T2 A5	23	27	100	43	19	39	15	25	22	46	27	24	20	45	32	27	54	11
T2 A6	22	33	43	100	37	31	14	38	20	51	27	25	8	47	35	35	40	20
T2 A7	16	26	19	37	100	13	31	19	-2	17	13	26	3	25	26	16	38	35
T2 A8	34	15	39	31	13	100	27	47	23	21	39	12	19	35	43	27	44	10
T2 A9	20	-17	15	14	31	27	100	11	-6	-10	25	-3	5	19	61	45	17	28
T2 B1	22	19	25	38	19	47	11	100	36	26	22	3	8	44	26	43	24	21
T2 B2	6	18	22	20	-2	23	-6	36	100	27	17	20	23	36	10	5	35	16
T2 B4	26	18	46	51	17	21	-10	26	27	100	25	10	-2	50	7	16	38	-5
T2 B5	32	12	27	27	13	39	25	22	17	25	100	-5	18	34	41	49	42	11
T2 B6	15	12	24	25	26	12	-3	3	20	10	-5	100	39	-7	-13	-8	36	12
T2 B7	39	27	20	8	3	19	5	8	23	-2	18	39	100	13	7	17	33	17
T2 C1	18	27	45	47	25	35	19	44	36	50	34	-7	13	100	51	53	36	39
T2 C2	11	2	32	35	26	43	61	26	10	7	41	-13	7	51	100	56	27	26
T2 C3	18	18	27	35	16	27	45	43	5	16	49	-8	17	53	56	100	35	49
T2 C4	29	34	54	40	38	44	17	24	35	38	42	36	33	36	27	35	100	18
T2 C5	10	22	11	20	35	10	28	21	16	-5	11	12	17	39	26	49	18	100

Appendix 18.1: Factor Array for Factor 2.1 (The Predictable Environment)

Factor 2.1

-5	-4	-3	-2	-1	0	1	2	3	4	5
24. Residents are able to take care of each other	41. We allow everyone to have some autonomy	**◀ 4. I need to feel supported to do my job	34. Not being condemning of others behaviour	22. I try to be a pro-social role model	**◀ 15. There need to be clear expectations about how people behave	**◀ 23. I keep in mind the whole resident group, not just the individual	**▶ 38. Everyone should be included	**▶ 40. I treat others fairly	**▶ 10. I am thoughtful about the resident's needs	**▶ 27. This needs to be a safe environment
8. Residents can depend on each other	**◀ 6. We have a genuine interest in each other	**◀ 39. I need clear reasons for all decisions that are made	*▶ 7. I do not take things at face value	49. Feeling safe to share our thoughts and emotions	9. We value everyone's ideas / thoughts	1. There needs to be a clear routine to the environment	*◀ 45. The boundaries between staff and resident relationships are clear	36. I ask myself about the need to keep the public safe	**▶ 5. I am confident in how to support residents	**▶ 17. Residents can depend on the staff to support them
	**◀ 25. I need strong leadership	35. I take responsibility for a sense of a community	**◀ 47. I feel respected and valued	**◀ 43. There needs to be predictable consequences for people's actions	**◀ 21. I ask myself 'how does this negative behaviour impact on others within this environment'?	**▶ 2. We must be genuine / authentic in how we treat others	**▶ 20. I value the resident's contributions to the environment	**▶ 28. All interactions with residents should be enabling	11. We work together as a team	
		**◀ 48. I value supervision	**◀ 33. We relate to each other with a sense of consistency and predictability	**◀ 29. We accept that people make mistakes	*◀ 14. We can trust each other	50. I am thoughtful about how others feel	**▶ 12. Everyone has a voice	3. I keep others welfare in my mind		
			**◀ 13. I try to be curious in why people behave in a certain way	**◀ 18. We need to be open to give and receive feedback	*◀ 42. We take a non-judgemental approach	**▶ 28. We take care of our environment	**▶ 37. I think about the resident's strengths and skills			
				**◀ 32. I look at the person not the problem	**◀ 31. We accept each other	46. We help each other to feel that they belong				
				**◀ 44. I keep in mind 'can we manage this type of behaviour'	**◀ 16. We should encourage residents to make their own choices	30. Residents can predictably get support when they need it				
					**◀ 19. We have shared goals about the culture between staff and residents					

Appendix 18.2: Factor Array for Factor 2.2 (Inclusion and Acceptance)

Factor 2.2

-5	-4	-3	-2	-1	0	1	2	3	4	5
24. Residents are able to take care of each other	31. We accept each other	20. I value the resident's contributions to the environment	34. Not being condemning of others behaviour	5. I am confident in how to support residents	30. Residents can predictably get support when they need it	4. I need to feel supported to do my job	40. I treat others fairly	44. I keep in mind 'can we manage this type of behaviour'	27. This needs to be a safe environment	43. There needs to be predictable consequences for people's actions
8. Residents can depend on each other	7. I do not take things at face value	23. I keep in mind the whole resident group, not just the individual	2. We must be genuine / authentic in how we treat others	46. We help each other to feel that they belong	49. Feeling safe to share our thoughts and emotions	14. We can trust each other	25. I need strong leadership	21. I ask myself 'how does this negative behaviour impact on others within this environment'?	45. The boundaries between staff and resident relationships are clear	15. There need to be clear expectations about how people behave
	29. We accept that people make mistakes	37. I think about the resident's strengths and skills	28. We take care of our environment	9. We value everyone's ideas / thoughts	50. I am thoughtful about how others feel	18. We need to be open to give and receive feedback	39. I need clear reasons for all decisions that are made	11. We work together as a team	36. I ask myself about the need to keep the public safe	
		41. We allow everyone to have some autonomy	19. We have shared goals about the culture between staff and residents	26. All interactions with residents should be enabling	13. I try to be curious in why people behave in a certain way	10. I am thoughtful about the resident's needs	1. There needs to be a clear routine to the environment	17. Residents can depend on the staff to support them		
			16. We should encourage residents to make their own choices	38. Everyone should be included	12. Everyone has a voice	32. I look at the person not the problem	3. I keep others welfare in my mind			
				33. We relate to each other with a sense of consistency and predictability	6. We have a genuine interest in each other	47. I feel respected and valued				
				35. I take responsibility for a sense of a community	22. I try to be a pro-social role model	42. We take a non-judgemental approach				
					48. I value supervision					

Appendix 19.1: Crib Sheet for Factor 2.1 (The Providing Team)

Relative Ranking of Statements in factor 2.1

Statements	Highest Ranked Statements	factor 2.1	Consensus / Distinguishing	factor 2.2
27	This needs to be a safe environment	5	D	4
17	Residents can depend on the staff to support them	5	D*	3
	Positive Statements Ranked Higher in factor 2.1 Array than in Other Factor Arrays			
10	I am thoughtful about the resident's needs	4	D*	1
5	I am confident in how to support residents	4	D*	-1
11	We work together as a team	4	C*	3
40	I treat others fairly	3	D	2
26	All interactions with residents should be enabling	3	D*	-1
3	I keep others welfare in my mind	3	C*	2
38	Everyone should be included	2	D*	-1
20	I value the resident's contributions to the environment	2	D*	-3
12	Everyone has a voice	2	D*	0
37	I think about the resident's strengths and skills	2	D*	-3
23	I keep in mind the whole resident group, not just the individual	1	D*	-3
2	We must be genuine / authentic in how we treat others	1	D*	-2
50	I am thoughtful about how others feel	1	C*	0
28	We take care of our environment	1	D*	-2
46	We help each other to feel that they belong	1	C*	-1
30	Residents can predictably get support when they need it	1	C*	0
9	We value everyone's ideas / thoughts	0	C*	-1
31	We accept each other	0	D*	-4
16	We should encourage residents to make their own choices	0	D*	-2
19	We have shared goals about the culture between staff and residents	0	D*	-2
	Negative Statements Ranked Lower in factor 2.1 Array than in Other Factor Arrays			
15	There need to be clear expectations about how people behave	0	D*	5
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	D*	3
14	We can trust each other	0	D	1
42	We take a non-judgemental approach	0	D	1
22	I try to be a pro-social role model	-1	C*	0
49	Feeling safe to share our thoughts and emotions	-1	C*	0
43	There needs to be predictable consequences for people's actions	-1	D*	5
18	We need to be open to give and receive feedback	-1	D*	1
32	I look at the person not the problem	-1	D*	1
44	I keep in mind 'can we manage this type of behaviour'	-1	D*	3
34	Not being condemning of others behaviour	-2	C*	-2
47	I feel respected and valued	-2	D*	1
33	We relate to each other with a sense of consistency and predictability	-2	C*	-1
13	I try to be curious in why people behave in a certain way	-2	D*	0
4	I need to feel supported to do my job	-3	D*	1
39	I need clear reasons for all decisions that are made	-3	D*	2
35	I take responsibility for a sense of a community	-3	C*	-1
48	I value supervision	-3	D*	0
41	We allow everyone to have some autonomy	-4	C*	-3
6	We have a genuine interest in each other	-4	D*	0
25	I need strong leadership	-4	D*	2
	Lowest Ranked Statements			
24	Residents are able to take care of each other	-5	C*	-5
8	Residents can depend on each other	-5	C*	-5

Appendix 19.2: Crib Sheet for Factor 2.2 (Safe Containment)

Relative Ranking of Statements in factor 2.2

			Consensus /	
	Highest Ranked Statements	**factor 2.2**	**Distinguishing**	**factor 2.1**
43	There needs to be predictable consequences for people's actions	5	D*	-1
15	There need to be clear expectations about how people behave	5	D*	0
	Positive Statements Ranked Higher in factor 2.2 Array than in Other Factor Arrays			
45	The boundaries between staff and resident relationships are clear	4	D	2
36	I ask myself about the need to keep the public safe	4	C*	3
44	I keep in mind 'can we manage this type of behaviour'	3	D*	-1
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	3	D*	0
25	I need strong leadership	2	D*	-4
39	I need clear reasons for all decisions that are made	2	D*	-3
1	There needs to be a clear routine to the environment	2	C*	1
4	I need to feel supported to do my job	1	D*	-3
14	We can trust each other	1	D	0
18	We need to be open to give and receive feedback	1	D*	-1
32	I look at the person not the problem	1	D*	-1
47	I feel respected and valued	1	D*	-2
42	We take a non-judgemental approach	1	D	0
49	Feeling safe to share our thoughts and emotions	0	C*	-1
13	I try to be curious in why people behave in a certain way	0	D*	-2
6	We have a genuine interest in each other	0	D*	-4
22	I try to be a pro-social role model	0	C*	-1
48	I value supervision	0	D*	-3
	Negative Statements Ranked Lower in factor 2.2 Array than in Other Factor Arrays			
30	Residents can predictably get support when they need it	0	C*	1
50	I am thoughtful about how others feel	0	C*	1
12	Everyone has a voice	0	D*	2
5	I am confident in how to support residents	-1	D*	4
46	We help each other to feel that they belong	-1	C*	1
9	We value everyone's ideas / thoughts	-1	C*	0
26	All interactions with residents should be enabling	-1	D*	3
38	Everyone should be included	-1	D*	2
34	Not being condemning of others behaviour	-2	C*	-2
2	We must be genuine / authentic in how we treat others	-2	D*	1
28	We take care of our environment	-2	D*	1
19	We have shared goals about the culture between staff and residents	-2	D*	0
16	We should encourage residents to make their own choices	-2	D*	0
20	I value the resident's contributions to the environment	-3	D*	2
23	I keep in mind the whole resident group, not just the individual	-3	D*	1
37	I think about the resident's strengths and skills	-3	D*	2
31	We accept each other	-4	D*	0
7	I do not take things at face value	-4	D	-2
29	We accept that people make mistakes	-4	D*	-1
	Lowest Ranked Statements			
24	Residents are able to take care of each other	-5	C*	-5
8	Residents can depend on each other	-5	C*	-5

Appendix 19.3: Consensus Statements at Time Two

Statement Number	Statement	Factor 2.1 Q-SV	Factor 2.1 Z-score	Factor 2.2 Q-SV	Factor 2.2 Z-score
1	There needs to be a clear routine to the environment*	1	0.357	2	0.715
3	I keep others welfare in my mind*	3	1.137	2	0.683
7	I do not take things at face value	-2	-0.71	-4	-1.39
8	Residents can depend on each other*	-5	-2.223	-5	-2.259
9	We value everyone's ideas / thoughts*	0	0.069	-1	-0.237
11	We work together as a team*	4	1.426	3	0.931
14	We can trust each other	0	-0.04	1	0.63
22	I try to be a pro-social role model*	-1	-0.293	0	-0.037
24	Residents are able to take care of each other*	-5	-1.974	-5	-2.019
27	This needs to be a safe environment	5	2.27	4	1.66
30	Residents can predictably get support when they need it*	1	0.184	0	0.212
33	We relate to each other with a sense of consistency and predictability*	-2	-0.744	-1	-0.387
34	Not being condemning of others behaviour*	-2	-0.705	-2	-0.731
35	I take responsibility for a sense of a community*	-3	-1.006	-1	-0.648
36	I ask myself about the need to keep the public safe*	3	1.24	4	1.346
40	I treat others fairly	3	1.32	2	0.75
41	We allow everyone to have some autonomy*	-4	-1.291	-3	-1.32
42	We take a non-judgemental approach	0	-0.18	1	0.41
45	The boundaries between staff and resident relationships are clear*	2	0.99	4	1.55
46	We help each other to feel that they belong*	1	0.214	-1	-0.122
49	Feeling safe to share our thoughts and emotions*	-1	-0.296	0	0.2
50	I am thoughtful about how others feel*	1	0.327	0	0.176

NB: All Listed Statements are Non-Significant at P > 0.01. Those Flagged with (*) are also Non-Significant at P > 0.05).

Appendix 20: Correlation Matrix for the Approved Premise Staff at Time Three

Correlations between Q sorts - Approved Premise Staff Time Three

Participant	T3 A2	T3 A4	T3 A5	T3 A6	T3 A7	T3 A8	T3 A9	T3 B1	T3 B2	T3 B5	T3 B6	T3 B7	T3 B8	T3 C1	T3 C2	T3 C3	T3 C4	T3 C5
T3 A2	100	-27	15	26	20	7	11	15	-13	19	18	36	-3	24	45	48	14	49
T3 A4	-27	100	18	4	7	-11	15	19	31	-8	6	-8	14	-4	3	-2	9	-5
T3 A5	15	18	100	48	49	20	42	40	31	40	56	14	11	34	24	35	49	18
T3 A6	26	4	48	100	43	24	38	35	28	49	56	25	2	40	54	32	42	47
T3 A7	20	7	49	43	100	18	41	35	11	26	42	27	-24	23	29	29	25	19
T3 A8	7	-11	20	24	18	100	5	22	14	2	30	22	-2	30	7	8	20	8
T3 A9	11	15	42	38	41	5	100	36	0	27	40	25	3	27	54	53	20	31
T3 B1	15	19	40	35	35	22	36	100	40	19	34	26	12	40	26	61	37	27
T3 B2	-13	31	31	28	11	14	0	40	100	4	30	3	13	14	3	5	21	3
T3 B5	19	-8	40	49	26	2	27	19	4	100	35	-9	19	39	21	49	30	21
T3 B6	18	6	56	56	42	30	40	34	30	35	100	24	10	33	40	26	52	17
T3 B7	36	-8	14	25	27	22	25	26	3	-9	24	100	-1	6	21	23	28	22
T3 B8	-3	14	11	2	-24	-2	3	12	13	19	10	-1	100	18	-5	23	39	4
T3 C1	24	-4	34	40	23	30	27	40	14	39	33	6	18	100	49	55	24	49
T3 C2	45	3	24	54	29	7	54	26	3	21	40	21	-5	49	100	50	16	58
T3 C3	48	-2	35	32	29	8	53	61	5	49	26	23	23	55	50	100	29	52
T3 C4	14	9	49	42	25	20	20	37	21	30	52	28	39	24	16	29	100	20
T3 C5	49	-5	18	47	19	8	31	27	3	21	17	22	4	49	58	52	20	100

Appendix 21.1: Factor Array for Factor 3.1 (Safety in the Environment)

Factor 3.1

-5	-4	-3	-2	-1	0	1	2	3	4	5
**▲ 24. Residents are able to take care of each other	35. I take responsibility for a sense of a community	48. I value supervision	**▶ 25. I need strong leadership	32. I look at the person not the problem	**▲ 3. I keep others welfare in my mind	18. We need to be open to give and receive feedback	5. I am confident in how to support residents	**▶ 4. I need to feel supported to do my job	**▶ 15. There need to be clear expectations about how people behave	**▶ 27. This needs to be a safe environment
8. Residents can depend on each other	**▲ 38. Everyone should be included	31. We accept each other	**▲ 7. I do not take things at face value	**▲ 29. We accept that people make mistakes	**▲ 42. We take a non-judgemental approach	44. I keep in mind 'can we manage this type of behaviour'	**▶ 39. I need clear reasons for all decisions that are made	**▶ 47. I feel respected and valued	11. We work together as a team	45. The boundaries between staff and resident relationships are clear
**▲ 23. I keep in mind the whole resident group, not just the individual	*▲ 6. We have a genuine interest in each other	37. I think about the resident's strengths and skills	34. Not being condemning of others behaviour	12. Everyone has a voice	**▶ 9. We value everyone's ideas / thoughts	**▶ 33. We relate to each other with a sense of consistency and predictability	22. I try to be a pro-social role model	40. I treat others fairly	**▶ 43. There needs to be predictable consequences for people's actions	
**▲ 41. We allow everyone to have some autonomy	**▶ 28. We take care of our environment	19. We have shared goals about the culture between staff and residents	30. Residents can predictably get support when they need it	50. I am thoughtful about how others feel	**▶ 36. I ask myself about the need to keep the public safe	13. I try to be curious in why people behave in a certain way				
20. I value the resident's contributions to the environment	**▲ 49. Feeling safe to share our thoughts and emotions	10. I am thoughtful about the resident's needs	**▲ 26. All interactions with residents should be enabling	**▶ 17. Residents can depend on the staff to support them						
**▲ 16. We should encourage residents to make their own choices	46. We help each other to feel that they belong	1. There needs to be a clear routine to the environment	2. We must be genuine / authentic in how we treat others							
**▲ 21. I ask myself 'how does this negative behaviour impact on others within this environment'?										

Appendix 21.2: Factor Array for Factor 3.2 (Understanding Our Impacts)

Factor 3.2

-5	-4	-3	-2	-1	0	1	2	3	4	5
35. I take responsibility for a sense of a community	**▲ 24. Residents are able to take care of each other	*▲ 4. I need to feel supported to do my job	**▲ 9. We value everyone's ideas / thoughts	12. Everyone has a voice	50. I am thoughtful about how others feel	**▶ 29. We accept that people make mistakes	*▲ 38. Everyone should be included	**▲ 27. This needs to be a safe environment	11. We work together as a team	45. The boundaries between staff and resident relationships are clear
8. Residents can depend on each other	**▲ 28. We take care of our environment	**▲ 39. I need clear reasons for all decisions that are made	19. We have shared goals about the culture between staff and residents	**▲ 15. There need to be clear expectations about how people behave	**▲ 14. We can trust each other	10. I am thoughtful about the resident's needs	**▶ 16. We should encourage residents to make their own choices	**▶ 17. Residents can depend on the staff to support them	**▶ 3. I keep others welfare in my mind	**▶ 36. I ask myself about the need to keep the public safe
	**▲ 47. I feel respected and valued	**▲ 25. I need strong leadership	**▲ 33. We relate to each other with a sense of consistency and predictability	32. I look at the person not the problem	**▲ 43. There needs to be predictable consequences for people's actions	5. I am confident in how to support residents	**▶ 49. Feeling safe to share our thoughts and emotions	**▶ 26. All interactions with residents should be enabling	**▶ 42. We take a non-judgemental approach	
		31. We accept each other	20. I value the resident's contributions to the environment	1. There needs to be a clear routine to the environment	18. We need to be open to give and receive feedback	13. I try to be curious in why people behave in a certain way	2. We must be genuine / authentic in how we treat others	40. I treat others fairly		
			48. I value supervision	37. I think about the resident's strengths and skills	30. Residents can predictably get support when they need it	**▶ 7. I do not take things at face value	**▶ 21. I ask myself 'how does this negative behaviour impact on others within this environment?			
				*▶ 6. We have a genuine interest in each other	34. Not being condemning of others behaviour	22. I try to be a pro-social role model				
				**▶ 41. We allow everyone to have some autonomy	**▶ 23. I keep in mind the whole resident group, not just the individual	44. I keep in mind 'can we manage this type of behaviour'				
					46. We help each other to feel that they belong					

Appendix 22.1: Crib Sheet for Factor 3.1 (Safety in the Environment)

Relative Ranking of Statements in factor 3.1

Statements	Highest Ranked Statements	factor 3.1	Consensus / Distinguishing	factor 3.2
27	This needs to be a safe environment	5	D*	3
45	The boundaries between staff and resident relationships are clear	5	C*	5
	Positive Statements Ranked Higher in factor 3.1 Array than in Other Factor Arrays			
15	There need to be clear expectations about how people behave	4	D*	-1
11	We work together as a team	4	C*	4
43	There needs to be predictable consequences for people's actions	4	D*	0
4	I need to feel supported to do my job	3	D*	-3
47	I feel respected and valued	3	D*	-4
14	We can trust each other	3	D*	0
40	I treat others fairly	3	C*	3
5	I am confident in how to support residents	2	C*	1
39	I need clear reasons for all decisions that are made	2	D*	-3
33	We relate to each other with a sense of consistency and predictability	2	D*	-2
22	I try to be a pro-social role model	2	C*	1
13	I try to be curious in why people behave in a certain way	2	C*	1
18	We need to be open to give and receive feedback	1	C*	0
44	I keep in mind 'can we manage this type of behaviour'	1	C*	1
9	We value everyone's ideas / thoughts	1	D*	-2
50	I am thoughtful about how others feel	1	C*	0
12	Everyone has a voice	0	C*	-1
30	Residents can predictably get support when they need it	0	C*	0
1	There needs to be a clear routine to the environment	0	C*	-1
	Negative Statements Ranked Lower in factor 3.1 Array than in Other Factor Arrays			
3	I keep others welfare in my mind	0	D*	4
42	We take a non-judgemental approach	0	D*	4
30	Residents can predictably get support when they need it	0	C*	0
10	I am thoughtful about the resident's needs	0	C*	1
26	All interactions with residents should be enabling	0	D*	3
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	0	D*	2
32	I look at the person not the problem	-1	C*	-1
29	We accept that people make mistakes	-1	D*	1
34	Not being condemning of others behaviour	-1	C*	0
49	Feeling safe to share our thoughts and emotions	-1	D*	2
16	We should encourage residents to make their own choices	-1	D*	2
46	We help each other to feel that they belong	-1	C*	0
7	I do not take things at face value	-2	D*	1
37	I think about the resident's strengths and skills	-2	C*	-1
20	I value the resident's contributions to the environment	-2	C*	-2
48	I value supervision	-3	C*	-2
31	We accept each other	-3	C*	-3
6	We have a genuine interest in each other	-3	D	-1
41	We allow everyone to have some autonomy	-3	D*	-1
38	Everyone should be included	-4	D*	2
23	I keep in mind the whole resident group, not just the individual	-4	D*	0
	Lowest Ranked Statements			
24	Residents are able to take care of each other	-5	D*	-4
8	Residents can depend on each other	-5	C*	-5

Appendix 22.2: Crib Sheet for Factor 3.2 (Understanding Our Impacts)

Relative Ranking of Statements in factor 3.2

Statements	Highest Ranked Statements	factor 3.2	Consensus / Distinguishing	factor 3.1
45	The boundaries between staff and resident relationships are clear	5	C*	5
36	I ask myself about the need to keep the public safe	5	D*	1
	Positive Statements Ranked Higher in factor 3.2 Array than in Other Factor Arrays			
11	We work together as a team	4	C*	4
3	I keep others welfare in my mind	4	D*	0
42	We take a non-judgemental approach	4	D*	0
17	Residents can depend on the staff to support them	3	D*	1
26	All interactions with residents should be enabling	3	D*	0
40	I treat others fairly	3	C*	3
38	Everyone should be included	2	D*	-4
49	Feeling safe to share our thoughts and emotions	2	D*	-1
16	We should encourage residents to make their own choices	2	D*	-1
2	We must be genuine / authentic in how we treat others	2	C*	1
21	I ask myself 'how does this negative behaviour impact on others within this environment'?	2	D*	0
29	We accept that people make mistakes	1	D*	-1
10	I am thoughtful about the resident's needs	1	C*	0
7	I do not take things at face value	1	D*	-2
44	I keep in mind 'can we manage this type of behaviour'	1	C*	1
30	Residents can predictably get support when they need it	0	C*	0
34	Not being condemning of others behaviour	0	C*	-1
23	I keep in mind the whole resident group, not just the individual	0	D*	-4
46	We help each other to feel that they belong	0	C*	-1
	Negative Statements Ranked Lower in factor 3.2 Array than in Other Factor Arrays			
50	I am thoughtful about how others feel	0	C*	1
14	We can trust each other	0	D*	3
43	There needs to be predictable consequences for people's actions	0	D*	4
18	We need to be open to give and receive feedback	0	C*	1
30	Residents can predictably get support when they need it	0	C*	0
12	Everyone has a voice	-1	C*	0
15	There need to be clear expectations about how people behave	-1	D*	4
32	I look at the person not the problem	-1	C*	-1
1	There needs to be a clear routine to the environment	-1	C*	0
9	We value everyone's ideas / thoughts	-2	D*	1
19	We have shared goals about the culture between staff and residents	-2	C*	-1
33	We relate to each other with a sense of consistency and predictability	-2	D*	2
20	I value the resident's contributions to the environment	-2	C*	-2
4	I need to feel supported to do my job	-3	D*	3
39	I need clear reasons for all decisions that are made	-3	D*	2
25	I need strong leadership	-3	D	-2
31	We accept each other	-3	C*	-3
28	We take care of our environment	-4	D*	-2
47	I feel respected and valued	-4	D*	3
	Lowest Ranked Statements			
35	I take responsibility for a sense of a community	-5	C*	-4
8	Residents can depend on each other	-5	C*	-5

Appendix 22.3: Consensus Statements at Time Three

Statement Number	Statement	Factor 3.1 Q-SV	Factor 3.1 Z-score	Factor 3.2 Q-SV	Factor 3.2 Z-score
1	There needs to be a clear routine to the environment*	0	-0.23	-1	-0.343
2	We must be genuine / authentic in how we treat others*	1	0.303	2	0.741
5	I am confident in how to support residents*	2	0.796	1	0.384
6	We have a genuine interest in each other	-3	-1.11	-1	-0.49
8	Residents can depend on each other*	-5	-2.139	-5	-2.373
10	I am thoughtful about the resident's needs*	0	-0.004	1	0.408
11	We work together as a team*	4	1.798	4	1.586
12	Everyone has a voice*	0	0.045	-1	-0.1
13	I try to be curious in why people behave in a certain way*	2	0.416	1	0.361
18	We need to be open to give and receive feedback*	1	0.395	0	0.026
19	We have shared goals about the culture between staff and residents*	-1	-0.411	-2	-0.63
20	I value the resident's contributions to the environment*	-2	-0.768	-2	-0.934
22	I try to be a pro-social role model*	2	0.426	1	0.27
25	I need strong leadership*	-2	-0.56	-3	-1.19
30	Residents can predictably get support when they need it*	0	0.03	0	0.016
31	We accept each other*	-3	-1.018	-3	-1.299
32	I look at the person not the problem*	-1	-0.383	-1	-0.278
34	Not being condemning of others behaviour*	-1	-0.406	0	0.005
35	I take responsibility for a sense of a community*	-4	-1.261	-5	-1.695
37	I think about the resident's strengths and skills*	-2	-0.706	-1	-0.403
40	I treat others fairly*	3	0.829	3	1.125
44	I keep in mind 'can we manage this type of behaviour'*	1	0.383	1	0.215
45	The boundaries between staff and resident relationships are clear*	5	2.006	5	1.888
46	We help each other to feel that they belong*	-1	-0.472	0	-0.08
48	I value supervision*	-3	-0.987	-2	-1.078
50	I am thoughtful about how others feel*	1	0.371	0	0.215

NB: All Listed Statements are Non-Significant at P > 0.01. Those Flagged with (*) are also Non-Significant at P > 0.05).

Appendix 23: Correlation Analysis Descriptive Information

Descriptive Statistics - Correlation Analysis Expert and Approved Premsie Staff Participants										
		EXP FA	EXP FB	EXP FC	Time 1 F 1	Time 1 F 2	Time 2 F 1	Time 2 F 2	Time 3 F 1	Time 3 F 2
N	Valid	50	50	50	50	50	50	50	50	50
	Missing	0	0	0	0	0	0	0	0	0
Mean		0.00000	-0.00002	0.00004	-0.00010	0.00000	-0.00002	0.00000	-0.00002	0.00004
Std. Deviation		1.000012	0.999950	0.999980	1.000000	1.000037	0.999949	0.999960	1.000078	0.999965
Percentiles	25	-0.78000	-0.90025	-0.71600	-0.79525	-0.77550	-0.70825	-0.75400	-0.61675	-0.69975
	50	0.11800	0.09950	-0.05700	0.07600	0.10600	-0.10900	0.06500	0.01300	0.02100
	75	0.84300	0.54875	0.66225	0.52875	0.79075	0.73750	0.71675	0.46050	0.76300